

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  03/18/2014
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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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G000000	<p>This was a home health federal complaint investigation.</p> <p>This survey was fully extended on 3/14/14 at 1:45 PM.</p> <p>Complaints: IN00145226 and IN00145297 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey Date: March 11 - 18, 2014</p> <p>Facility #: 7377</p> <p>Medicaid #: 200873250</p> <p>Surveyors: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor</p> <p>Incare Home Healthcare Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning March 28, 2014, to March 28, 2016, due to being found out of compliance with the Conditions of Participation 42 CFR 484.10 Patient Rights; 484.14 Organization, services, and administration; 484.16: Group of Professional Personnel; 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; 484.48: Clinical Records; and 484.55 Comprehensive Assessment of Patients.</p> <p>The Administrator informed of the above-stated preclusion at the exit</p>	G000000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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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G000100	<p>conference held on 3/18/14 at 11:50 AM.</p> <p>Skilled Patients: 116 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 28, 2014</p> <p>Based on observation, clinical record and agency policy review, agency document review, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure patients had been informed of their rights in 2 of 12 records reviewed creating the potential to affect all future new admissions to the agency (See G 101); failed to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency (See G 107); and by failing to ensure patients had been provided with current written information regarding advance directives in 12 of 12 records reviewed creating the potential to affect all future admissions to the agency (See G 110).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.10 Patient Rights.</p>	G000100	<p><b>All chart are being audited for deficient practices.Majority of nurses assigned to patient have been replaced.Administrator has In-serviced nursing staff on Patient Rights. Patients re-educated and received Patients' Rights and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and responsibilities and a copy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited. Administrator to audit 10% of existing patient charts weekly for compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</b></p>	04/17/2014	
G000101	484.10 PATIENT RIGHTS				

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	<p>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 agency document review, policy review, clinical record review, and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 2 of 12 clinical records reviewed with the potential to affect all the patients of the agency. (# 2, 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 2, start of care 2/19/14, failed to evidence the patient had been notified of the patient rights.</li> <li>Clinical record #9, start of care 12/11/13, failed to evidence the patient had been notified of the patient rights.</li> <li>On 3/18/14 at 10:45 AM, Employee A, the administrator / director of nursing indicated the documentation of the patient rights' acknowledgement was not in the records noted above.</li> <li>The agency policy titled "Home Care Bill of Rights / Grievance procedure" with no effective date stated, "Patients will be informed of their right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Agency will provide a mechanism in which a patient's complaint can be processed and resolved promptly and efficiently ... To protect and promote the exercise of patient's rights."</li> <li>The agency document titled "Patient bill of</li> </ol>	G000101	<p><b>All chart are being audited for deficient practices. Majority of nurses assigned to patient have been replaced.</b></p> <p><b>Administrator has In-serviced nursing staff on Patient Rights and grievance process.</b></p> <p><b>Patients re-educated and received Patients' Rights, grievance process and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and responsibilities, grievance process and a copy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited.</b></p> <p><b>Administrator to audit 10% of existing patient charts weekly for compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</b></p>	04/17/2014

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G000107	<p>rights and responsibilities" with no effective date stated, "The Patient or 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 as follows: the home health agency shall provide the patient with a written notice of the patient rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. the home health agency shall maintain documentation showing that it has complied with the requirements of this section."</p> <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 policy review, clinical record review, administrative document review, and interview, the agency failed to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include</p> <p>1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective</p>	G000107	All staff have been instructed on the policy and process for receiving, documenting and resolving patient grievances. Staff has been instructed on the use of the complaint log, patient grievance form and that all patient grievances or concerns are to be brought to the attention of the DON and/or the Administrator in a timely manner for follow up, investigation and resolution. Staff will be in-serviced on hire, annually and as necessary on the right of patient to have grievances				

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G000110	<p>date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</p> <p>2. The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities."</p> <p>3. Clinical record #12, start of care 10/23/13, evidenced the patient had received the patient rights at the start of care.</p> <p>4. On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed a complaint due to lack of requested toenail care and also lack of home health aide services as had been planned with care planning. Patient #12 had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</p> <p>5. On 3/14/14 at 2:45 PM, the administrator indicated the complaint had not been filed in the complaint log.</p> <p>6. A review of the complaint log and other agency documentation failed to evidence any investigation or other documentation concerning the complaint filed by patient #12.</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p>		<p>acknowledged and fully investigated and informed of the resolution of their grievance as outlined in the Grievance Policy. The DON and/or the administrator will review all grievances and ensure that investigation, resolution and documentation take place. The DON and the Administrator will be responsible for monitoring and ensuring that this deficiency does not recur.</p>		

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	<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, observation, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced directives, including a description of applicable State law, in 12 of 12 records reviewed (#1 - 12) with the potential to affect all the active patients of the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC).</li> <li>2. On 3/14/14 at 2 PM, the administrator / director of nursing indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patients #5, #6, #7 home admission books and that all the patients of the agency needed to receive</li> </ol>	G000110	<p><b>All chart are being audited for deficient practices. Majority of nurses assigned to patient have been replaced. Updated Advanced Directives copied and distributed for nurses to re-educate patients. All admission packets Advanced Directives replaced with current 2013 revised copy. All patients to receive updated version and education on Advanced Directives. All old copies of Advanced Directives replaced with 2013 revision. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur and will review at quarterly quality meeting.</b></p>	04/17/2014	

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	<p>the updated advanced directives.</p> <p>3. Clinical record #1, SOC 1/17/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record #2, SOC 12/11/13 failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. There was no evidence in the record that the patient had received the patient rights.</p> <p>5. Clinical record #3, SOC 10/24/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record #4, SOC 10/21/10, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record #5, SOC 12/30/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 11 AM, the home admission book was observed in the home for patient #5. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>8. Clinical record #6, SOC 11/2/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives</p>			

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	<p>document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 3:30 PM, the home admission book was observed in the home for patient #6. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>9. Clinical record #7, SOC 7/26/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/17/14 at 1:10 PM, the home admission book was observed in the home for patient #7. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>10. Clinical record #8, SOC 11/7/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had signed that the document was received on the SOC date.</p> <p>11. Clinical record #9, SOC 11/7/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had not received the patient rights.</p> <p>12. Clinical record #10, SOC 5/3/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #11, SOC 2/27/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives</p>			

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G000121	<p>document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #12, SOC 10/23/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date. 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 observation, interview, and professional standard review, the agency failed to ensure its staff had provided services in accordance to professional standards in 2 of 3 home visit observations (patient #6 and 7) completed creating the potential to affect any patients cared for by this registered nurse. (Employees E and I)</p> <p>The findings include</p> <p>1. On 3/13/14 at 3:30 PM, Employee E, home health aide, was observed to give a partial bath to patient #6. Employee E did not change gloves during the course of this bath despite changing the water in the basin before washing the peri area. She washed the patient's face, arms, chest, back, legs, feet, perineal area, anal area, and buttocks in that order without changing her gloves. She obtained a clean wash cloth for the peri care wash and changed the water before this time of the bath.</p>	G000121	<p><b>Employee E re-educated on gloving during bathing according to Administrative Standards for the ISDH Nurse Aide Training Manual.</b></p> <p><b>Employee I re-educated on Hand washing Technique per Policy D330 of Clinical Procedure Manual Home Health Aide staff re-in-service on Topic 17 Bathing, Procedure 33 bed bath and Procedure 2 gloves (Administrative Standards for the Indiana State Dept. of Health Nurse Aide Training Program). All nursing staff re-educated on Hand washing Procedure D330 of Clinical Procedure Manual.</b></p> <p><b>Administrator or designee observe hand washing and proper gloving by observing all home health aides and nurses to monitor for 6 months randomly Administrator will</b></p>				

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G000122	<p>a. On 3/14/14 at 4:20 PM, the administrator / director of nursing indicated the gloves should have been changed after washing the rectal area. She indicted she had given the agency procedure to the employee last week. She indicated that she would give this policy to the observer.</p> <p>b. On 3/17/14 at 5:10 PM, the agency was unable to provide a procedure for giving a bath.</p> <p>2. On 3/17/14 at 2:40 PM at a home visit observation, Employee I, Registered Nurse, was observed to wash her hands prior to caring for Patient #7. She washed her hands with bar soap found in the patient's bathroom for 30 seconds and then dried with a paper towel.</p> <p>a. On 3/17/13 at 3:55 PM, the administrator / director of nursing indicated Employee I should not use bar soap for hand washing prior to patient care.</p> <p>b. A nursing procedure titled "Infection Prevention: Keeping it clean" with a date of March / April 2009 stated, "Wet your hands and wrists with warm water, and apply soap from a dispenser. Don't use bar soap because it allows cross-contamination. This was retrieved on 3/21/14 at 11 PM at <a href="http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf">http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf</a> 484.14</p> <p>ORGANIZATION, SERVICES &amp; ADMINISTRATION</p> <p>Based on policy review, interview, and agency document review, it was determined</p>	G000122	<p><b>be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p> <p><b>Speech Therapy Services provided by St John Therapy Services per long-standing contract. DON, Administrator, ADON and Alternate</b></p>		

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G000123	<p>the agency failed to ensure the organizational chart included speech therapy services for 1 of 1 agency with the potential to affect all the patients of the agency (See G 123), failed to ensure the governing body had been active in the agency during the last 2 years for 1 of home health agency reviewed with the potential to affect all the patients of the agency(See G 128), failed to ensure the governing body appointed the administrator with the potential to affect all patients of the agency (See G 129), failed to ensure the Governing Body adopted and periodically reviewed written bylaws or an acceptable equivalent for 1 of 1 agency reviewed with the potential to affect all the agency's patients (See G 131), failed to ensure the Governing Body oversaw the management and fiscal affairs of the agency for 1 of 1 agency with the potential to affect all the agency's patients (See G 132), failed to ensure the administrator implemented an effective budget and accounting system for 1 of 1 agency with the potential to affect all 116 active patients of the agency (See G 136), and failed to ensure the personnel policies were followed in 8 if 17 records reviewed of employees with the potential to affect all the patients of the agency (see G 141).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, services, and administration.</p> <p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in</p>		<p><b>Administrator no longer with agency. Current administrative staff on service since Jan/Feb 2014. Governing Body stepping down from position. PAC meeting March 20,2014 (conference call) accepted Administrator. By-Laws, financial and fiscal information located and organized in a secure location. Recent transition, administrator locating all documents and securing Formal PAC meeting scheduled 4/7/14 to address items in entirety. Agency has retained Paychex on 3/7/14 for HR organization, education and management of files. Governing Body, Bi-Laws and Financial and budgetary information placed in one location. IT specialist retained to access locked programs and access deleted files, manuals and records. The Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure that the deficiency is corrected and will not recur.</b></p>		

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G000128	<p>writing and are readily identifiable.</p> <p>Based on document review and interview, the agency failed to ensure the organizational chart included speech therapy services for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. The agency's organizational chart, dated 2/19/09, failed to identify the agency had a speech therapist.</p> <p>2. On 3/17/14 at 11:15 AM, Employee A, the administrator / director of nursing, indicated the speech therapy services were part of the agency services.</p> <p>484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.</p> <p>Based on policy and administrative document review and interview, the agency failed to ensure the governing body had been active in the agency during the last 2 years for 1 of home health agency reviewed with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing indicated that the governing body had not had any</p>	G000123	<p><b>Organizational Chart Updated.</b> <b>Organizational chart to be maintained by administrator or designee. Organizational chart will be reviewed quarterly at quality meeting The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</b></p>	04/17/2014
		G000128	<p>The Governing Body meet on March 20, 2014 and appointed Lisa Maguria RN as the administrator and has delegated the authority and responsibilities for the provision of home care services in accordance with state and federal regulations, accreditation standards and the agency mission. By laws have been adopted and reviewed. The POC has been appointed and has subsequently met on April 7, 2014. An annual operational budget and capital expenditure plan has been developed. The</p>	

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G000129	<p>meetings since 2012.</p> <p>2. A review of agency documents failed to show that the governing body had met in 2013 or 2014.</p> <p>3. On 3/17/14 at 11:15 AM, Employee A indicated the by - laws could not be found.</p> <p>4. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. Special instructions The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibilities for the provision of home care services in accordance with state and federal regulations, accreditation stands, and agency mission. 2. Appoint the Professional Advisory Board ... as required by the state licensure and / or Medicare Conditions of Participation to guide the organization in the formulation and review of policies and procedures and ensure the highest quality of patient care 3. Adopt and periodically review and approve the administrative and personnel policies, patient care policies and procedures, by laws ... annual operating budget and capital expenditure plan. 4. Oversee the management and fiscal affairs of the agency."</p> <p>484.14(b) GOVERNING BODY The governing body appoints a qualified administrator.</p>			G000129	<p>personnel,administrative, and patient policies and procedures were reviewed. The members of the Governing Body are: Jerry Fozzard Owner, Lisa Magura BSN, RN Administrator. New members have been oriented tothe GB and their respective duties. A roster of membership of the Governing Body has been implemented. The Governing Body will meet at least annually and as needed. The Administrator will act as the liaison between the Governing Body and the Professional Advisory Committee. Documentation inthe form of GB minutes of the Governing Body meeting will be done with each meeting and reviewed and signed. The Administrator or designee will be responsible for monitoring of these corrective actions to ensure that this deficiency does not recur.</p> <p>The Governing Body met on March 20, 2014 and appointed</p>		

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G000131	<p>Based on agency policy and document review and interview, the home health agency failed to ensure the governing body appointed the administrator with the potential to affect all patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. A review of agency documents failed to evidence the agency's governing body had met in 2013 or 2014. There was no documentation to evidence the administrator had been appointed by the governing body.</li> <li>2. On 3/17/14 at 11:15 AM, the administrator indicated the agency had no documentation to show that the governing body had appointed her as administrator.</li> <li>3. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. Special instructions The duties and responsibilities of the governing body shall included 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations, accreditation stands, and agency mission."</li> </ol> <p>484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent.</p>	G000131	<p>Lisa Magura BSN, RN as the administrator and has delegated the authority and responsibilities for the provision of home care services in accordance with state and federal regulations, accreditation standards and the agency mission. The Governing Body will meet at least annually and as needed. The Administrator will act as the liaison between the Governing Body and the ProfessionalAdvisory Committee. Documentation in the form of GB minutes of the Governing Body meeting will be done with each meeting and reviewed and signed. TheGoverning Body will be responsible for appointing an Administrator at such timethe current administrator vacates the position. The Governing Body will be responsible for monitoring of these corrective actions to ensure that this deficiency does not recur.</p> <p>The Governing Body meet on March 20,2014 and the by laws</p>		

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G000132	<p>Based on agency policy and document review and interview, the home health agency failed to ensure the Governing Body adopted and periodically reviewed written bylaws or an acceptable equivalent for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of agency documents failed to evidence the agency's governing body had met in 2013 or 2014. Documentation failed to evidence the governing body had adopted and periodically reviewed the bylaws.</li> <li>2. On 3/17/14 at 11, the 11:15 AM, the administrator / director of nursing indicated there was no documentation showing that the governing body had met in 2013 or 2014 and had reviewed the by - laws of the agency.</li> <li>3. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services ... 3. Adopt and periodically review ... by laws" 484.14(b)</li> </ol> <p>GOVERNING BODY The governing body oversees the management and fiscal affairs of the agency.</p> <p>Based on agency policy and agency document review and interview, the home health agency failed to ensure the Governing Body oversaw the management and fiscal</p>	G000132	<p>were presented, reviewed and adopted as noted in the minutes.</p> <p>The Governing Body will meet at least annually and as needed. The Administrator will act as the liaison between the Governing Body and the Professional Advisory Committee. Documentation in the form of GB minutes of the Governing Body meeting will be done with each meeting and reviewed and signed. The by-laws will be reviewed at least annually at the Governing Body meeting and documented in the minutes.</p> <p>The Administrator and the Governing Body will be responsible for monitoring of these corrective actions to ensure that this deficiency does not recur.</p> <p>The Governing Body meet on March 20, 2014 and appointed Lisa Magura BSN, RN as the administrator and has delegated the authority and responsibilities for the provision of home care</p>				

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G000136	<p>affairs of the agency for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of agency documents failed to evidence the agency's governing body had met in 2013 or 2014. There was no documentation to evidence the governing body oversaw the management and fiscal affairs of the agency.</li> <li>2. On 3/17/14 at 11:15 AM, the administrator / director of nursing indicated there is no documentation showing that the governing body had met in 2013 or 2014 and had oversaw the management and fiscal affairs of the agency.</li> <li>3. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. Special instructions The duties and responsibilities of the governing body shall include ... 4. Oversee the management and fiscal affairs of the agency."</li> </ol> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section,</p>		<p>services in accordance with state and federal regulations, accreditation standards and the agency mission. By laws have been adopted and reviewed. The POC has been appointed and has subsequently met on April 7, 2014. An annual operational budget and capital expenditure plan has been developed. The personnel, administrative, and patient policies and procedures were reviewed. The members of the Governing Body are: Jerry Fozzard Owner, Lisa Magura BSN RN Administrator. New members have been oriented to the GB and their respective duties. A roster of membership of the Governing Body has been implemented. The Governing Body will meet at least annually and as needed. The Administrator will act as the liaison between the Governing Body and the Professional Advisory Committee. Documentation in the form of GB minutes of the Governing Body meeting will be done with each meeting and reviewed and signed. The Administrator and Governing Body will be responsible for monitoring of these corrective actions to ensure that this deficiency does not recur.</p>		

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G000141	<p>implements an effective budgeting and accounting system.</p> <p>Based on agency document review and interview, the home health agency failed to ensure the administrator implemented an effective budgeting and accounting system for 1 of 1 agency with the potential to affect all 116 active patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of agency documents failed to evidence the administrator had implemented an effective budgeting and accounting system.</li> <li>On 3/17/14 at 11, the 11:15 AM, the administrator / director of nursing indicated there is no documentation showing the administrator had implemented an effective budgeting and accounting system.</li> </ol> <p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on personnel file and policy review, and interview, the agency failed to ensure the personnel policies were followed in 7 of 17 personnel records reviewed (File A, C, F, H, I, K, O) of employees with the potential to affect all the patients of the agency.</p>	G000136	<p><b>84% office staff replaced. Biller and former Admin exited business Feb 2014. Current admin working towards retrieving information. Information organized and budget being established with oversight of Medicare Consultant. CEO and administrator to establish financial organization to maintain all financial records to effectively manage budget and accounting system. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p>	04/17/2014			
			G000141	<p><b>Missing physicals/tb and Administrator job description were located in former alternate administrator's drawer in a mislabeled file. Documents placed in appropriate file. Physicals for RN A and C were performed prior to first patient contact. All missing nursing personnel TB</b></p>			

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	<p>Findings</p> <ol style="list-style-type: none"> <li>Personnel file A, administrator / director of nursing, date of hire 12/30/13 and first patient contact 1/22/14, failed to evidence a physical examination and signed job description for the administrator position.</li> <li>Personnel file C, Registered Nurse (RN), date of hire 3/4/14 and first patient contact 3/4/14, failed to evidence a physical examination that showed the employee was free of communicable diseases and an annual evaluation since hire.</li> <li>Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to show verification of occupational therapy license, criminal history verification, physical examination, annual tuberculosis screening, job description, and orientation.</li> <li>Personnel file H, RN, date of hire 1/3/11 and unknown first patient contact, failed to evidence an annual evaluation since date of hire.</li> <li>Personnel file I, RN, date of hire 7/12/12 and first patient contact 7/14/12, failed to evidence an annual evaluation.</li> <li>Personnel file K, RN, date of hire 9/25/13 and first patient contact 1/23/13, failed to evidence a limited criminal history or expanded criminal history.</li> <li>Personnel file O, contract physical therapist with unknown date of hire and first patient contact, a contract therapist failed to show verification of physical therapy license, criminal history verification, physical</li> </ol>		<p><b>testing located with physicals. Former administrator responsible for files. Records were obtained for contracted therapists F and O and found to be current. RN K is no longer employed with agency. Performance Evals for employee I to be presented to employee. Employee H is no longer employed with agency. Administrator conducted an audit of employee personnel files on March 25, 2014. On March 7, 2014, the administrator entered agreement with payroll company Paychex to audit and manage HR files, assist in developing formal orientation program and develop a more structured comprehensive employee manual. Administrator or designee will utilize employee checklist on all new employees and completeness will be checked by Administrator prior to first contact. All employees hired before March 2013 will receive performance evaluation. Competencies will be checked by outside agency for HHAs. All file audit by HR designee. 100% then random Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this</b></p>	

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	<p>examination, annual tuberculosis screening, job description, and orientation.</p> <p>8. The agency policy titled "License, Registration, or Certification Requirements" with no effective date stated, "If a position requires licensure, registration, or certification, it shall be the employee's responsibility to keep these documents current ... a copy of the employee's currently license certification shall be maintained in his / her personnel file."</p> <p>9. The agency policy titled "Health Screening" stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients. This includes, at a minimum, TB [tuberculosis] via the Mantoux method ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy ... On any employee or contract personnel providing direct patient care, there shall be documentation of completion of a tuberculin [TB] skin test, via the Mantoux method. OSHA requires two - step testing. If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within three weeks of the first test."</p> <p>10. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually</p>		<b>deficiency does not recur.</b>		

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G000151	<p>thereafter."</p> <p>11. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>12. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing indicated the above files were incomplete.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>Based on policy review and document review and interview, it was determined the agency failed to ensure a Group of Professional Personnel that included at least physician and other health care professionals had met since 2012 for 1 of 1 agency creating the potential to affect all of the agency's current patients (See G 152),ailed to ensure a Group of Professional Personnel established and annually reviewed the agency's policies for 1 of 1 agency creating the potential to affect all of the agency's current patients(See G 153), failed to ensure a Group of Professional Personnel met frequently to advise the agency on professional issues, participate in</p>	G000151	<p><b>Professional Advisory Committee has been re-established 3/20/2014 and second follow-up meeting to be scheduled 4/7/2014 to address any identified issues. Meeting will then be conducted annual in Jan and as needed. Calendar of all Administrative meetings created. PAC informed of expectations and policies. Administrator will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</b></p>				

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G000152	<p>the evaluation of the agency's program and to assist in maintaining liaison with other health professionals for 1 of 1 agency creating the potential to affect all of the agency's current patients (See G 154), and failed to ensure a Group of Professional Personnel met and meetings were documented by dated minutes 2012 for 1 of 1 agency creating the potential to affect all of the agency's current patients (See G 155).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.16: Group of Professional Personnel.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines.</p> <p>Based on policy review, agency document review, and interview, the agency failed to ensure a Group of Professional Personnel that included at least physician and other health care professionals had met since 2012 for 1 of 1 agency creating the potential to affect all of the agency's current patients.</p> <p>The findings include</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to show that the professional advisory committee had met in 2013 or 2014.</li> <li>2. On 3/13/14 at 10:15 AM, Employee A, the</li> </ol>	G000152	<p>Professional advisory committee established and initial meeting March 20, 2014. On April 7,2014 a meeting was held. The PAC consists of Dr Jose Agusti (MD), Jerry Fozzard(CEO), Lisa Magura BSN RN (administrator), Rebecca Shellito RN (ADON), Judith Schmitz LPN, Tara Plahetka HHA, Ian Cabello (Therapy), Carmen Pavese(consumer), MSW is pending. Meeting followed policy. Committee members advised of the guideline of meeting annually and as needed. Meetings to take place first quarter yearly and as needed. Policy and Procedure</p>	

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G000153	<p>administrator / director of nursing, indicated the Professional Advisory Committee had not met since 2012.</p> <p>3. The agency policy titled "Professional Advisory Board" with no effective date stated, "A group of professional personnel shall be established. This group shall meet frequently, at least annually ... the objectives of the advisory committee include: A. Provide supervision of the clinical aspects of the program including utilization of services B. Provide medical consultation to professional staff C. Promote home health in the community D. Review and approve admission, discharge, clinical record policies, and personnel qualifications E. Participate in an annual review of the agency's home care program." 484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.</p> <p>Based on policy review, agency document review, and interview, the agency failed to ensure a Group of Professional Personnel established and annually reviewed the agency's policies for 1 of 1 agency creating the potential to affect all of the agency's current patients.</p>	G000153	<p>Clinical, Organizational, Personnel and Documentation Manuals reviewed and approved. Administrator to organize and coordinate meetings including assuring members are notified in advance of upcoming meetings and will follow guidelines and maintain minutes. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p> <p>PAC meeting April 7, 2014 reviewed and approved Policy and Procedure Clinical,Operational, Personnel and Documentation manuals. Documentation placed in each binder. Addition of a personnel policy reviewed and approved. Meeting followed agenda and minutes documented. Agenda</p>				

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G000154	<p>The findings include</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to show that the professional advisory committee had met in 2013 or 2014.</li> <li>2. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing, indicated the Professional Advisory Committee had not met since 2012.</li> <li>3. The agency policy titled "Professional Advisory Board" with no effective date stated, "A group of professional personnel shall be established. This group shall meet frequently, at least annually ... the objectives of the advisory committee include: A. Provide supervision of the clinical aspects of the program including utilization of services B. Provide medical consultation to professional staff C. Promote home health in the community D. Review and approve admission, discharge, clinical record policies, and personnel qualifications E. Participate in an annual review of the agency's home care program." 484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.</li> </ol> <p>Based on policy review, agency document review, and interview, the agency failed to ensure a Group of Professional Personnel</p>	G000154	<p>template initiated and identifies reviewing of policies and procedures on an annual basis. Proprietor and administrator have reviewed all policies related to group of professional personnel and will monitor the need for additional meetings (in three months). The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p> <p>A PAC meeting was held on April 7, 2014. The PAC was established by the Governing Body that includes representation from each scope of service,</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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G000155	<p>met frequently to advise the agency on professional issues, participate in the evaluation of the agency's program and to assist in maintaining liaison with other health professionals for 1 of 1 agency creating the potential to affect all of the agency's current patients.</p> <p>The findings include</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to show that the professional advisory committee had met in 2013 or 2014.</li> <li>2. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing, indicated the Professional Advisory Committee had not met since 2012.</li> <li>3. The agency policy titled "Professional Advisory Board" with no effective date stated, "A group of professional personnel shall be established. This group shall meet frequently, at least annually ... the objectives of the advisory committee include: A. Provide supervision of the clinical aspects of the program including utilization of services B. Provide medical consultation to professional staff C. Promote home health in the community D. Review and approve admission, discharge, clinical record policies, and personnel qualifications E. Participate in an annual review of the agency's home care program."</li> </ol> <p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's meetings are documented by dated minutes.</p>	G000155	<p>including a nurse, therapist, a physician and a community liaison. The following items were discussed. Reviewed and approved, Home Care mission and vision, Governing Body and PAC roles and responsibilities, Home Care mission and vision, overview of the organizational chart, Personnel qualifications of Supervising Nurse and Alternate approvals, scope of service and counties served, policies: administrative, governing, clinical and personnel, procedure manual, annual agency program evaluation and performance improvement plan, Chart review results, infection control and exposure plans, emergency/disaster plan, corporate compliance plan, Budget, and capital expenditure plan. A roster, signed minutes and orientation to the PAC completed. The next PAC meeting has been scheduled for July 18, 2014 and quarterly for the remainder of 2014 and at least annually thereafter with additional meetings as indicated.</p> <p>The Administrator or designee is responsible for monitoring the corrective actions and ensuring that this deficiency does not recur.</p> <p>The PAC committee has met. Membership included</p>		

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G000156	<p>Based on policy review, agency document review, and interview, the agency failed to ensure a Group of Professional Personnel met and meetings were documented by dated minutes 2012 for 1 of 1 agency creating the potential to affect all of the agency's current patients.</p> <p>The findings include</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to show that the professional advisory committee had met in 2013 or 2014.</li> <li>2. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing, indicated the Professional Advisory Committee had not met since 2012.</li> <li>3. The agency policy titled "Professional Advisory Board" with no effective date stated, "A group of professional personnel shall be established. This group shall meet frequently, at least annually ... the objectives of the advisory committee include: A. Provide supervision of the clinical aspects of the program including utilization of services B. Provide medical consultation to professional staff C. Promote home health in the community D. Review and approve admission, discharge, clinical record policies, and personnel qualifications E. Participate in an annual review of the agency's home care program."</li> </ol> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was</p>			G000156	<p>representation from each scope of service (including an RN), a physician, therapist and an individual from the community. Reviews of the agency policies, scope of services, admission, discharge, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation were done. The agency annual evaluation was reviewed. The appointment of the administrator by the GB was noted and discussed. A PAC meeting will be scheduled quarterly for the remainder of this year by the Administrator. A PAC meeting will take place at minimum annually or more frequently as needed and the Administrator will ensure the PAC meetings are scheduled and conducted timely.</p> <p><b>Patient 12 had requested podiatrist care. On 2/26/14 DON contacted Home Physicians to request podiatry service at request of patient. Received</b></p>		

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G000157	<p>determined the agency failed to meet the needs of 1 of 12 clinical records reviewed with the potential to affect any patient of the agency (See G 157), failed to ensure treatments and services had been provided in accordance with physician's orders in 7 of 12 records reviewed creating the potential to affect all of the agency's 116 active patients (see G 158), failed to ensure the plan of care included all required elements for 9 of 12 records reviewed with skilled nursing with the potential to affect all the agency's patients (See G 159), and failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed with the potential to affect all of the agency's active patients (See G 164),</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p>		<p><b>call back from Home physicians indicating patient has changed insurance from Medicare to Humana. Home podiatry not covered under policy. Informed patient that he does not have insurance coverage for podiatry under Humana. Patient instructed to contact insurance or Medicare. 3/12/14 followed up with patient. He stated he contacted Humana. HIQ shows patient "Null" in insurance coverage. Informed by physician that Medicare will be resumed on 4/1/14. Informed patient. Patient states not sure if he needs aide service at this time. Patient denies complaint. Patient stated very grateful for assist in insurance benefit information. All new admission packets will be reviewed for completeness by Administrator or designee. Admitting RN will be notified of any discrepancies. Nursing staff re-educated on grievance procedure and patients re-educated on grievance procedure. The DON or designee will be responsible All new admission packets will be reviewed for completeness by DON or designee. Admitting RN will be notified of any discrepancies.</b></p>		

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	<p>Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.</p> <p>Based on policy review, clinical record review, administrative document review, and interview, the agency failed to meet the needs of 1 of 12 clinical records reviewed ( #2) with the potential to affect any patient of the agency.</p> <p>Findings include</p> <p>1. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13 and failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14 or the current certification period that has unknown dates. The patient is still an active patient and filed a complaint due to the lack of home health aide services needed and the lack of a podiatrist's care despite an order for this. There was no documentation in the record that the patient received care from a podiatrist. There were no aide visits noted in the record. The patient had signed receiving the patient rights at the start of care.</p> <p>a. A clinical record document titled "Fax" and a date of 11/21/13 stated, "Patient to see podiatrist." This was signed by the physician and Employee I, RN.</p> <p>b. On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed a complaint due to lack of requested toe nail care and also lack of home health aide</p>	G000157	<p>The Administrator has provided education to the Clinical Intake coordinator (who collects the initial patient information and referral)and the RN case managers (who provide the initial evaluation and assessment forhome care needs, medical necessity and homebound status) on the CoP and policies concerning the admission of patients who the agency can provide thescope of service that the patient needs. Instructed to identify the scope of service needs and ensure that those needs can be met by the agency. Instructed to discuss any concerns about meeting the scope of service with the DON and/or the Administrator. 100% of the clinical records have been audited to determine that all patient needs are being met as ordered. A Podiatrist has been secured to see the patient. Aide services are available and have been scheduled for the patient. The option of transferring to another homecare was offered and declined. All staff have been instructed on the policy and process for receiving, documenting and resolving patient grievances. Staff has been instructed on the use of the complaint log, patient grievance</p>	04/17/2014

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	<p>services as had been planned with care planning. Patient #12 indicated the patient had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</p> <p>c. A review of the complaint log failed to evidence this complaint.</p> <p>d. On 3/14/14 at 2:45 PM, the administrator indicated the complaint had not been filed in the complaint log and the plan of care was not in the record for recertification periods and indicated no documentation was present about the home health aide services or lack of a podiatrist visit.</p> <p>e. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</p> <p>2. The agency policy titled "Patient Admission Process" with no effective date stated, "If the agency cannot fulfill the required health need, a referral will be made to other appropriate community resources and referral source will be notified."</p> <p>3. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in</p>		<p>form and that all patient grievances or concerns are to be brought to the attention of the DON and/or the Administrator in a timely manner for follow up, investigation and resolution. Staff will be in-serviced on hire, annually and as necessary on the right of patient to have grievances acknowledged and fully investigated and informed of the resolution of their grievance as outlined in the Grievance Policy. The DON and/or the administrator will review all grievances and ensure that investigation, resolution and documentation take place. The DON will review each referral for appropriateness for admission and determine that the scope of service needs can be met. Case conferences will be regularly scheduled to determine and discuss on going patient needs and that needs are being met and appropriate referrals are being done. 10% of the clinical records will be reviewed quarterly to ensure that the patient scope of service needs are being met. The DON or designee will be responsible for the monitoring of the correction plan to ensure that this deficiency does not recur.</p>	

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G000158	<p>compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs." 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure treatments and services had been provided in accordance with physician's orders in 7 of 12 records (2, 3, 4, 7, 8, 9, 12) reviewed creating the potential to affect all of the agency's 116 active patients.</p> <p>Findings</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse</p>	G000158	All active charts audited for deficient practices. 5 RNs (84%) of skilled nursing staff are no longer with agency. (1)Nurses educated/re-educated on components of nursing assessment and following plan of care, (policy D145). All new SOC documents submitted are reviewed for accuracy.Skilled nurses re-educated on patient assessment, following physician orders and teaching. (2) Nurses re-educated on pain assessment,interventions and documentation (policy C148). (3) Nurse J no longer employed with agency. (4) Nurse I re-educated on following physicians orders, the plan of care, care coordination and frequency compliance. Nurse I counselled on obtaining weights as ordered. (4) All charts audited for presence of therapy orders, glucose monitoring and frequencies. Physician notified of any	

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	<p>oximetry every visit. The record failed to evidence the skilled nurse performed these tasks at the initial assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 4/4/14 and evidenced the plan of care was not followed.</p> <p>a. This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks and the home health aide (HHA) was to visit 1 - 2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26 and HHA visits on 2/5/14. There were no other SN and HHA visits in the record.</p> <p>b. Additionally, this plan of care included orders for the skilled nurse to give Vitamin B12 1000 mcg per ml monthly subcutaneous.</p>		<p>discrepancies identified. Charts audited for frequencies and physician notified if discrepancies were identified. Staff educated on following the ordered frequency. (5) Nurse G is no longer employed with agency. All patient charts were audited for wounds and for appropriate orders and documentation. (6) Charts were audited for presence of plan of care. Office staff educated on filing plan of care immediately and process initiated for timely printing of all documents. Administrator or designee will audit 10% of patient charts weekly for presence and adherence to the plan of care and documentation supporting the plan of care is being followed. Audits will include monitoring for the completion of assessments, pain assessment and interventions, skin care, treatments, presence of wounds, wound assessments, wound care, weights, glucose monitoring and monitoring frequencies being followed. Transition to Axxess EMR integrates a comprehensive detailed nursing assessment. Staff educated on orders to be followed at all times and physician notification for any discrepancies or changes in the patient's condition. Therapy log initiated to track orders, notification and visits. Office staff oriented to SOC audits and weekly audits to monitor frequencies. All scheduling and documentation</p>	

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	<p>This medication was documented as being given in the antecubital space on February 26, 2014, by Employee J, registered nurse (RN). It was not documented if this was given as an intramuscular injection or subcutaneous injection.</p> <p>c. Via telephone call, on 3/14/14 at 12:30 PM, Patient #4 indicated that the registered nurse, Employee J, had given the Vitamin B 12 injection into the upper left arm at the last visit.</p> <p>d. On 3/14 2:20 PM, the administrator / director of nursing indicated the Vitamin B12 injection was to be given subcutaneous and this was not documented and did not follow the plan of care. Employee A indicated the nurse had written in error that the injection had been given into the antecubital space.</p> <p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p> <p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>4. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 with orders for physical therapy and occupational therapy, and no orders for glucose testing.</p>		<p>requirements are to be transitioned to Axxess which immediately flags missed visits or frequency discrepancies. All staff educated on policies; Medical Supervision, Scope of Practice and Plan of Care. Nurse's inserviced on the risks and consequences of not following the physician ordered plan of care. An additional nurse with previous homecare experience is employed in office. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p>	

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	<p>a. The plan of care for the certification period of 11/7/13 - 1/5/14 evidenced that the patient was to receive physical therapy 1 - 2 times a week for 5 weeks and Occupational therapy visits 1 - 2 times a week for 5 weeks. No visits were made.</p> <p>b. The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>c. On 3/14/14 at 3:18 PM, the administrator / director of nursing indicated the above visits and lack of visits did not follow the plan of care.</p> <p>5. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance, assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p> <p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to</p>			

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	<p>show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p> <p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>6. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, the administrator / director of nursing indicated the plan of care was not in the record for this certification period.</p> <p>7. The agency policy titled "Medical Supervision" with no effective date stated, "A physician plan of care is developed for each patient at the time of admission and signed by the physician in the appropriate time frame</p>			

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	<p>... agency responsibilities include prompt reporting of a change in patient condition ... support of a physician plan of care."</p> <p>8. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p> <p>9. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... 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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for</p>			

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G000159	<p>changes in the plan of care."</p> <p>10. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet." 484.18(a) PLAN OF CARE 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 home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements for 9 of 12 records reviewed (#1, #2, #3, #4, #6, #7, #8, #9, #12) with skilled nursing with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, primary diagnosis of Osteoarthritis and start of care (SOC) date 1/17/14, contained a plan of care (POC) for 1/17/14 - 3/17/14 that stated, "Care by 3/17/14." There were no measurable goals or outcomes for this patient.</p> <p>On 3/14/14 at 2:35 PM, Employee A, the</p>	G000159	All charts audited for the deficient practices. 84% of nurses no longer employed with agency and 100% office staff no longer with agency.(1,2)All patients identified with incomplete plan of care documentation were clarified with physician, completed and appropriately submitted to the patients physician. (4,7)Nurses educated on mandatory requirement of signing plan of care and submitting within 48 hours of completion of assessment. (5) Nurses educated on mandatory requirement of obtaining and adhering to physician ordered frequencies. Education to RN case mangers provided on the need to establish and document measurable goals on the POC. A	

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	<p>administrator / director of nursing, indicated the goals on the plan of care were not measurable.</p> <p>2. Clinical record #2, primary diagnosis of asthma and SOC date 12/11/13, contained a POC for 12/11/13 - 2/8/14 with orders for skilled nurse visits 1 - 2 times a week for 9 weeks. There were no measurable goals or outcomes for this patient. The physician's signature on this POC was dated 1/14/14.</p> <p>On 3/14/14 at 3:50 PM, Employee A indicted the goals on this plan of care were not measurable.</p> <p>3. Clinical record #3, primary diagnosis of Alzheimer's disease and SOC date of 10/24/13, contained a POC for 12/23/13 - 2/20/14 with orders for skilled nurse visits 1 - 2 times a week. The POC failed to evidence a timely signature of the physician with a physician's signature on 2/4/14. The skilled nurse had not signed the verbal order in box 23 of this POC. This POC lacked measurable goals.</p> <p>On 3/14/14 at 1:57 PM, Employee A indicated the registered nurse had not signed the POC and the physician had not signed the POC and the goals on the POC were not measurable.</p> <p>4. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 4/2/14 that failed to evidence a nurse's signature and date of verbal order and a physician's signature.</p> <p>On 3/11/14 at 4:35 PM, Employee A indicated the POC failed to include a doctor's</p>		<p>fax log and tracking system of checkingfor returned signed POC and verbal orders established; education provided to professional staff on the need for physician orders for all care and treatments to be provided to the patient. (6) Nurses educated on completing plan of care in entirety and list any and all DME and equipment. (8) Nurse identified for this patient is no longer employed with agency. (9) Nursing educated regarding the requirement of an active plan of care in order to provide services for patient. The DON/Alternate DON or nursing designee will audit 10% of charts weekly to ensure completion of plan of care, and that it is appropriate forpatient. The DON/Alternate DON or nursing designee will monitor all patient start of care and re-certifications for appropriate, complete and timely submission of the plan of care. All plan of cares will be monitored to include appropriate signatures and dates. The DON/Alternate DON or nursing designee will monitor all scheduling and clinical documentation to be in compliance with the frequencies noted on the plan of care. Axxess system transition will provide numerous auditing and tracking systems and submissions will be more timely as it is electronic. TheDON/Alternate DON or nursing designee will be responsible for monitoring these</p>	

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	<p>signature or nurse's signature.</p> <p>5. Clinical record #6, SOC 11/2/13 and primary diagnosis of pressure ulcer stage 1, included a plan of care for the certification period of 3/2/14 - 4/30/14 that failed to evidence the frequency of the home health aide (HHA) and skilled nurse (SN) visits. SN visits occurred on 3/4/14 and the HHA visits occurred on 3/1/14, 3/4/14, 3/6/14 and 3/13/14.</p> <p>On 3/14/14 at 2 PM, Employee A, administrator and director of nursing, indicated the frequency and duration of skilled nurse and HHA visits were not on the plan of care.</p> <p>6. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, that failed to evidence the patient had a wheelchair and walker.</p> <p>a. On 3/17/14 at 1:10 PM, it was observed that the patient had a wheelchair and walker.</p> <p>b. On 3/18/13 at 3:55 PM, Employee A indicated the plan of care was not complete.</p> <p>7. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 that failed to evidence a nursing signature with the verbal order or a physician order for this plan of care.</p> <p>On 3/14/14 at 3:18 PM, Employee A, administrator, failed to evidence a physician's signature or verbal order to start care.</p> <p>8. Clinical record #9, start of care (SOC)</p>		<p>corrective actions and will be reviewed at quarterly to ensure the deficiency is corrected and will not recur.</p>				

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	<p>2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included wound care but the plan of care did not specify the type of wound care to be provided.</p> <p>9. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, Employee A indicated the plan of care was not in the record for this certification period.</p> <p>10. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of car 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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the</p>			

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G000164	<p>severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care." 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p>	G000164	The Administrator/DON have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will	

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G000168	<p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician. 484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure skilled nursing services had been provided by the registered nurse with physician's orders in 6 of 12 records reviewed creating the potential to affect all of the agency's 116 active patients (See G 170), failed to ensure the registered nurse completed the initial assessment visit to determine the immediate care and support needs of the patients for 1 of 12 records reviewed with the potential to affect all new patients of the agency (see G 171), failed to ensure the registered nurse</p>	G000168	<p>not recur.</p> <p><b>Skilled Nurses re-educated on Clinical Policy D145 Comprehensive Patient Assessment. Re-education on plan of care and certification process per Medicare guidelines. Notification of change in condition in-service given to all nursing staff. Administrator or designee to audit 10%patient charts weekly for comprehensive assessment, certification dates, noted changes in condition, adherence to plan of</b></p>				

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G000170	<p>reevaluated the patient's need at least every 60 days for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (See G 172), and failed to ensure the registered nurse promptly alerted the physician to changes in the patient's condition for 2 of 12 records reviewed with the potential to affect all of the agency's active patients (see G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 484.30 Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services had been provided by the registered nurse with physician's orders in 6 of 12 records (2, 3, 4, 7, 8, 9) reviewed creating the potential to affect all of the agency's 116 active patients.</p> <p>Findings</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment,</p>	G000170	<p><b>care. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p> <p>All active charts audited for deficient practices. 5 RNs (84%) of skilled nursing staff are no longer with agency. (1)Nurses educated/re-educated on components of nursing assessment and following plan of care, (policy D145). All new SOC documents submitted are reviewed for accuracy. Skilled nurses re-educated/inserviced on patient assessment, following physicians orders and patient education. (2) Nurses inserviced on pain assessment, interventions and documentation (policy C148). (3) Nurse J no longer employed with agency. (4) Nurse I re-educated on following physicians orders, the plan of care, care coordination and frequency compliance. (4) All</p>				

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	<p>disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse oximetry every visit. The record failed to evidence the skilled nurse performed these tasks at the initial assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 2/4/14 and evidenced the plan of care was not followed.</p> <p>This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26/14. There were no other SN visits in the record.</p>		<p>charts audited for presence of therapy orders, glucose monitoring and frequencies. Physician notified of any discrepancies identified. Charts audited for frequencies and physician notified if discrepancies were identified. Staff educated on following the ordered frequency. (5) Nurse G is no longer employed with agency. All patient charts were audited for wounds and audited for appropriate orders and documentation. (6) Charts were audited for presence of plan of care. Office staff educated on filing plan of care immediately and process initiated for timely printing of all documents. Administrator or designee will audit 10% of patient charts weekly for presence of the plan of care and documentation the plan of care is being followed. Audits include monitoring for the completion of assessments, pain assessment and interventions, skin care, treatments, presence of wounds, wound assessments, wound care, weights, glucose monitoring and monitoring that frequencies are being followed. Transition to Axxess EMR integrates a comprehensive detailed nursing assessment. Staff educated on orders to be followed at all times and physician notification for any discrepancies or changes in the patient's condition. Therapy log initiated to track orders, notifications and visits. Office</p>				

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	<p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p> <p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>5. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 that failed to evidence orders for glucose testing.</p> <p>The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>6. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance,</p>		<p>staff oriented to SOC packet contents and weekly audits to monitor frequencies. All scheduling and documentation requirements are to be transitioned to Axxess flags frequency discrepancies. All staff educated on policies; Medical Supervision, Scope of Practice and Plan of Care. Nurse's inserviced on the risks and consequences of not following the physician ordered plan of care. A nurse with previous homecare experience is hired for office to assist in ensuring services are provided as ordered and monitoring compliance. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p>	

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	<p>assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p> <p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p> <p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>7. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p>			

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G000171	<p>8. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... 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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."</p> <p>9. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered</p>	G000171	All charts audited for initial assessments and and missing information including referral dates. Staff educated on completing all documentation in	

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G000172	<p>nurse completed the initial assessment visit to determine the immediate care and support needs of the patients for 1 of 12 records reviewed (1) with the potential to affect all new patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. The initial assessment was not completed. There was no referral date in the record.</p> <p>2. On 3/14/13 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the initial assessment was not in the record.</p> <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 and interview, the agency failed to ensure the registered nurse reevaluated the patient's need at least every 60 days for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days. (#2 and #4).</p> <p>Findings include:</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 and 2/9/14 - 4/9/14. The record failed to evidence the registered nurse completed a comprehensive recertification assessment.</p>	G000172	<p>its entirety and not omitting date. Employee responsible for processing patient files no longer employed with agency. Employee responsible to completion of initial assessment no longer with agency. Administrator or designee will monitor completeness of all pre-admit documentation on a weekly basis. Pre-admission audit tool to be implemented. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur</p> <p>All charts audited for the presence of timely re-assessments. Office staff re-educated on filing re-certification and documentation timely. If assessment has been completed in Genie system, it is to be printed and filed timely. Employee responsible for notifying staff of re-certifications due and filing of assessments is no longer employed at agency. Nurses have been re-educated on re-certification timelines and timely submission of documentation. 5 of the nurses responsible are no longer with agency. Administrator will monitor the completion of re-assessments</p>	

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G000176	<p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>2. Clinical record #6, SOC 11/2/13, included plans of care for the certification periods of 1/1/14 - 3/1/14 and 3/2/14 - 4/30/14. The record failed to evidence the registered nurse had completed a comprehensive recertification assessment.</p> <p>On 3/14/14 at 2:10 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <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 clinical record review and interview, the agency failed to ensure the registered nurse promptly alerted the physician to changes in the patient's condition for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease</p>	G000176	<p>by using a re-certification list and checking on a weekly basis. Administrator or designee to schedule all skilled visits including re-certification assessments in Axxess. Scheduled tasks appear on the screen with the appropriate assessment forms selected. Additional nursing staff hired to prevent this deficient practice from recurring. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p> <p><b>The Administrator/DON have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to</b></p>	

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G000202	<p>process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician.</p> <p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on clinical record review and interview,</p>	G000202	<p><b>include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted.</b></p> <p>Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance.</p> <p>The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p><b>All chart are being audited for deficient practices. Nursing staff re-educated on requirements related to home</b></p>	

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G000224	<p>it was determined the agency failed to ensure the home health aide care plan was updated in 2 of 8 records reviewed of patients receiving aide services creating the potential to affect patients with aide services (See G 224) and failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 1 of 8 records reviewed of patients that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services (See G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.36: Home Health Aide Services.</p> <p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure the home health aide care plan was updated in 2 of 8 records reviewed of patients receiving aide services (3 and 7) creating the potential to affect patients with aide services.</p> <p>Findings</p> <p>1. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care</p>	G000224	<p><b>health aide services and supervision. 84% nursing staff no longer with agency. Nurses have been given both paper and electronic means of developing aide care plan. Patients with aide services will receive updated care plans. Administrator or designee will monitor 10% of charts weekly for aide supervision and presence of care plan. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p> <p>Allhome health aide care plans have been audited for completion and compliancewith review by the RN at minimum every 60 days. The professional RN staff has been educated on the necessity of updating the home health aide care plan at least every 60 days and when necessary based on a change in patient need/condition. TheDON or designee will audit each SOC and recertification for a home health aide care plan and necessary review and updates.</p>				

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G000229	<p>(SOC)10/24/13, contained a plan of care for 12/23/13 - 2/20/14 with orders for home health aide visits 1 - 2 times a week for 9 weeks. The aide care plan had not been updated since 10/24/13. Aide visits were made on 2/3/14, 2/7/14, 2/10/14, 2/13/14, and 2/17/14.</p> <p>On 3/14/14 at 1:56 PM, Employee A, administrator / director of nursing, indicated the aide care plan had not been updated every 60 days.</p> <p>2. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, contained a plan of care for 12/21/13 - 3/22/14 with orders for skilled nursing once a week and for home health aide visits (the frequency and duration was not ordered). The aide care plan had not been updated since 7/26/13. Home health aide visits were made on 12/23/13, 12/29/13, 12/31/13, 1/4/14, 1/7/14, 1/14/14, 1/18/14, 1/21/14, 1/25/14, and 1/28/14.</p> <p>On 3/18/14 at 11 AM, Employee A indicated the aide care plan had not been updated since 7/26/13.</p> <p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 1 of 8 records reviewed of patients (#5) that</p>	G000229	<p>10%of the clinical records will be audited every quarter for compliance with60-day updates and review of the home health aide care plan.</p> <p>TheDON/Alternate DON will be responsible for monitoring these corrective actionsand is responsible for ensuring this deficiency does not recur.</p> <p><b>All chart are being audited for deficient practices. Nurses were re-educated on the policy Home Health Aide Supervision and aide care plan. Supervision to be scheduled in Axxess system. Administrator or</b></p>	

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G000235	<p>received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services.</p> <p>Findings</p> <p>1. Clinical record #5 evidenced home health aide services had been provided 1- 2 times a week for 9 weeks during the certification period of 12/30/13 - 2/27/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 12/30/13 - 2/27/14 by the registered nurse.</p> <p>2. On 3/14/14 at 3:20 PM, the administrator / director of nursing indicated the aide supervision had not occurred at the for the time period identified.</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain clinical records in accordance with its own policy in 3 of 12 records reviewed creating the potential to affect all of the agency's patients (See G 236).</p> <p>The cumulative effect of this problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Medical Records.</p>	G000235	<p><b>designee will monitor 10% of charts weekly for aide supervision. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p> <p><b>Administrator and designee have gone through all drawers and cabinets in agency and all medical records were placed in appropriate area/chart/file. All filing to be done in a timely manner and not to be placed in inappropriate areas. Administrator or designee to monitor cubicles two times weekly for documents for filing and monitor that fax confirmations are attached to orders. Monitor that there is always a copy of documents in patients chart if awaiting a signature. Transition to Axxess to reduce filing. Administrator will be responsible for</b></p>		

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G000236	<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 and agency policy review and interview, the agency failed to maintain clinical records in accordance with its own policy in 3 of 12 records reviewed (1, 3, 4) creating the potential to affect all of the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 1/17/1 and primary diagnosis of Osteoarthritis, included a plan of care for the certification period of 1/17/14 - 3/17/14. There was no initial assessment in the record at this time. The initial assessment was found outside of the record on 3/14/14.</p> <p>On 3/14/14 at 2:35 PM, the administrator / director of nursing indicated the clinical record had missing documentation.</p>			G000236	<p><b>monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p> <p><b>Administrator and designee have gone through all drawers and cabinets in agency and all medical records were placed in appropriate area/chart/file. All filing to be done in a timely manner and not to be placed in inappropriate areas. Administrator or designee to monitor cubicles two times weekly for documents for filing and monitor that fax confirmations are attached to orders. Monitor that there is always a copy of documents in patients chart if awaiting a signature. Transition to Axxess to reduce filing. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting</b></p>		

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G000321	<p>2. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care 10/24/13, contained plans of care for 12/23/13 - 2/20/14 and 2/21/14 - 2/21/14. The record failed to evidence a recertification assessment when the record was reviewed on 3/12/14.</p> <p>On 3/14/14 at 1:55 PM, the administrator / director of nursing indicated the recertification for 2/17/14 had not been present in the record and was found and placed in the record. This document should have been placed in the record in a timely manner.</p> <p>2. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, failed to evidence a start of care assessment and medication profile.</p> <p>On 3/14/14 at 2:20 PM, Employee J indicated the SOC assessment and medication profile were missing from the record.</p> <p>3. The agency policy titled "Clinical records / Medical Record Retention" and no effective date stated, " Clinical record [is] A confidential clinical record containing pertinent past and current findings in accordance with professional standards is maintained for every patient receiving home health services." 484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on clinical record review, Indiana State</p>	G000321	<p><b>to ensure this deficiency does not recur.</b></p> <p>Individuals responsible for transmissions is no longer with the agency. All OASIS to be transmitted by no later than April</p>		

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	<p>Department of Health (ISDH) document review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion of the assessment in 6 (patients # 1 - 4, 8, 12) of 12 records reviewed of patients that received skilled services and required OASIS data be collected and transmitted to the state creating the potential to affect all of the agency's current patients that are required to have OASIS data collected and transmitted.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care 1/17/14, failed to include a start of care comprehensive assessment. No assessment had been transmitted to the state. This patient is a Medicare patient with skilled service including skilled nursing and is over 18 years of age.</li> <li>2. Clinical record #2, start of care 12/11/13, is an active patient with the agency. The patient's last assessment transmission occurred on 12/27/13 for the start of care assessment completed on 12/11/13. The patient did not have a plan of care for the certification period of 2/9/14 - 4/9/14. The patient had a plan of care for the certification period of 12/11/13 - 2/8/14. This patient has Medicare, is over 18, and has skilled nursing services.</li> <li>3. Clinical record #3, start of care 10/24/13, is an active patient with the agency. The patient's last assessment transmission occurred on 11/24/13 with a start of care assessment completed 10/24/13. This patient has Medicare, is over 18, and received skilled service.</li> </ol>		<p>17, 2014. Owner of agency is obtaining necessary passwords and login for billing specialist. This individual is designated representative for OASIS submission. Administrator will monitor for compliance by keeping a weekly OASIS submission log. Administrator and a designee will obtain training and login/password to perform this task as needed by May 17,2014. Administrator or designee will obtain a list from billing weekly containing a list of all submissions and administrator or designee will compare to Oasis tracking log to begin April 24,2014. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p>				

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G000330	<p>4. Clinical record #4, start of care 10/21/10, was an active patient with the agency until 3/9/14. This patient's last assessment transmission occurred on 10/14/13 with a recertification assessment completed 10/2/13. The last certification periods were 2/2/14 - 4/2/14 and 12/4/13 - 2/1/14.</p> <p>5. Clinical record #8, start of care 11/7/13 and discharge 12/5/13, failed to include a start of care assessment, discharge assessment, or any documentation of assessment transmissions to the state. The patient has Medicare, is over 18, and received skilled service from the agency.</p> <p>6. Clinical record #12 failed to include a recertification assessment for the time period after a plan of care for the certification period of 12/22/13 - 2/19/14. The patient is still an active patient, is over 18 years old, has Medicare, and has skilled nursing services. No assessment transmissions occurred after 12/17/13.</p> <p>7. On 3/13/14 at 9:45 AM, the administrator indicated being locked out of the OASIS program and not knowing the password. She indicated OASIS reports were not submitted in February 2014.</p> <p>8. Indiana State Department of Health Documents failed to evidence any assessments were received in February. A phone call placed to the agency to query why the agency had not sent any assessments on 3/6/14 at 3:336 PM resulted in a busy signal. The same thing happened on 3/7/14 at 2: 20 PM.</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS</p>						

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	<p>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and policy review, and interview, it was determined the agency failed to maintain compliance with this condition to ensure the registered nurse completed the initial assessment to determine the immediate care and support needs of the patients for 1 of 12 records reviewed with the potential to affect all new patients of the agency (see G 331), the registered nurse had made an initial assessment visit within 48 hours of referral in 4 of 12 records reviewed creating the potential to affect all of the agency's new patients (See G 332), failed to ensure the registered nurse totally and accurately completed the comprehensive assessment</p>	G000330	Allchart are being audited for deficient practices. Majority of nurses assigned topatient have been replaced Nurses were re-educated oninitial/comprehensive assessment requirements in relation to conditions ofparticipation. Office staff re-educated regarding placing date on day referrals received. Administrator or designee will audit 10% ofcharts weekly to ensure compliance. All referrals to be entered into Axxess attime of referral which gives date stamp. If paper referral is used,administrator will monitor that date is added.	04/17/2014			

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G000331	<p>for 6 of 12 records reviewed with the potential to affect all new patients of the agency (see G 334), failed to ensure the registered nurse completed a recertification comprehensive assessment for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (See G 338), and failed to ensure the comprehensive assessment had been updated at the time of discharge from the agency in 3 (# 8, #10, #11) of 3 discharged records reviewed (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed the initial assessment to determine the immediate care and support needs of the patients for 1 of 12 records reviewed (1) with the potential to affect all new patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. The initial assessment was not completed. There was</p>	G000331	<p>Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p> <p>G331 All chart are being audited for deficient practices. Majority of nurses assigned to patient have been replaced. Nurses were re-educated on initial/comprehensive assessment requirements in relation to conditions of participation. Office staff re-educated regarding placing date on day referrals received. Administrator or designee will audit 10% of charts weekly to ensure compliance. All referrals to be entered into Axxess attime</p>	

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G000332	<p>no referral date in the record.</p> <p>2. On 3/14/13 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the initial assessment was not in the record.</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit within 48 hours of referral in 4 of 12 records (#1, 2, 3, 9) reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. There was no referral date in the record so it was unable to be determined if any initial assessment visit was made timely.</p> <p>On 3/14/13 at 2:35 PM, Employee A, the administrator / director of nursing, indicated there was no referral date in the record.</p> <p>2. Clinical record #2 identified a SOC of 12/11/13. There was no referral date in the record so it was unable to be determined if any initial assessment visit was made timely.</p>	G000332	<p>of referral which gives date stamp. If paper referral is used, administrator will monitor that date is added. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p> <p>Intake coordinator no longer employed with agency. All current office staff re-educated on placing date on referral the day the referral information is taken. Transition to Axxess automatically date stamps referral. Administrator to monitor each referral for completeness including date. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p>		

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G000334	<p>On 3/14/14 at 3:55 PM, Employee A indicated there was no referral date in the record.</p> <p>3. clinical record #3 identified a SOC of 11/2/13. There was no referral date in the record so it was unable to be determined if any initial assessment visit was made timely.</p> <p>On 3/14/14 at 2 PM, Employee A indicated the referral was not dated.</p> <p>4. Clinical record #9 identified a SOC of 2/19/14. There was no referral date in the record so it was unable to be determined if any initial assessment visit was made timely.</p> <p>On 3/18/14 at 10 AM, Employee A indicated no referral date was in the record.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record and interview, the agency failed to ensure the registered nurse totally and accurately completed the comprehensive assessment for 6 of 12 records reviewed (1, 2, 4, 8, 9, 12) with the potential to affect all new patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. The comprehensive assessment was not completed.</p>	G000334	The DON has conducted in-services with all RN case management staff on the need for a SOC comprehensive assessment on every patient, the need for the assessment to be complete with all elements addressed and accurate. The RN case managers were in-serviced on the patient right that they participate in the planning of their care and the documentation to indicate collaborative planning with the patient took place. 100% of the clinical records have	

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	<p>On 3/14/13 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the comprehensive assessment was not in the record.</p> <p>2. Clinical record #2, SOC 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 with orders for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse oximetry every visit. The start of care comprehensive assessment had not been completed and failed to show the patient's history, pain level, endocrine / hematology, pressure sore risk, cardiopulmonary, genitourinary, psychosocial , fall risk, endocrine, respiratory, neurological, home environment / safety, pressure sore risk, medication teaching / patient compliance, oxygen level, and physical assessments / status. The plan of care did not show that the patient had participated in the plan of care. This section was left blank.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the comprehensive assessment was incomplete.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, failed to evidence a start of care assessment.</p>		<p>audited for the abovedeficiencies and have been addressed with the appropriate professional. Theclinical documentation will be reviewed by the DON for compliance withcompletion of the comprehensive assessment and inclusion of the patient in thatplanning of their care. 10% of the clinical records will be audited quarterly for compliance with the completion of thecomprehensive assessment and inclusion of the patient in the planning of theircare. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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G000338	<p>On 3/14/14 at 2:20 PM, Employee A indicated the SOC assessment was not in the record.</p> <p>4. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, failed to evidence a start of care assessment.</p> <p>On 3/14/14 at 3:18 PM, Employee A, administrator, indicated that no start of care assessment was in the record.</p> <p>5. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, failed to evidence a start of care assessment.</p> <p>On 3/18/14 at 10 AM, Employee A indicated the start of care assessment was not in the record.</p> <p>6. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment which failed to indicate the correct gender for the patient. The patient's name was gender - oriented.</p> <p>On 3/11/14 at 4:30 PM, Employee A indicated the gender was not correct on the start of care assessment.</p> <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 and interview, the agency failed to ensure the registered</p>	G000338	The DON has conducted in-services with all RN case management staff on the need for a timely recertification	

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G000341	<p>nurse completed a recertification comprehensive assessment for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days. (#2 and #4).</p> <p>Findings include:</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 and 2/9/14 - 4/9/14. The record failed to evidence the registered nurse completed a comprehensive recertification assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>2. Clinical record #6, SOC 11/2/13, included plans of care for the certification periods of 1/1/14 - 3/1/14 and 3/2/14 - 4/30/14. The record failed to evidence the registered nurse had completed a comprehensive recertification assessment.</p> <p>On 3/14/14 at 2:10 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p> <p>Based on clinical record and agency policy</p>	G000341	<p>comprehensive assessment on every patient within the 56-60 daywindow, the need for the assessment to be complete with all elements addressedand accurate. 100% of the clinical records have audited for the abovedeficiencies and have been addressed with the appropriate professional. Theclinical documentation will be reviewed by the DON for compliance withcompletion of the recertification comprehensive assessment and that it fallswithin the 56-60 day window. A tracking tool has beendeveloped to alert the RN case managers for pending recertification timelines 10% of the clinical recordswill be audited quarterly for compliance with the completion of therecertification comprehensive assessment. The Administrator will be responsible for monitoring the corrective action to assure this deficiency iscorrected and will not recur.</p> <p>The Administrator/DON have conducted in-services with all nursing staff to address the regulations,policies and procedures on transfer and</p>		

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	<p>review and interview, the agency failed to ensure the comprehensive assessment had been updated at the time of discharge from the agency in 3 (# 8, #10, #11) of 3 discharged records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record #8 evidenced skilled nursing services had been provided 1 times per week for 4 weeks during the certification period 11/7/13 - 1/5/14. The record evidenced the patient had been discharged and failed to include a discharge assessment.</p> <p>A. On 3/14/14 at 3 PM, The record included a posted note on the front of the record that stated, "D/C." There was no other indication in this record that the patient had been discharged.</p> <p>B. On 3/14/14 at 3:10 PM, Employee A, administrator / director of nursing indicated the discharge assessment had not been completed.</p> <p>2. Clinical record #10 evidenced skilled nursing services had been provided 1 - 2 times a week for 1 week and 1 times a week for 8 weeks during the certification period 12/29/13 - 2/26/13 and 2 times a week for 1 week and 1 times a week for 8 weeks during the certification period of 2/27/14 - 4/27/14. The discharge occurred on 3/10/14. The record failed to include a discharge assessment.</p> <p>A. A document from another home health agency titled "Beneficiary elected transfer dated 3/9/14 and signed by patient #10 stated, "I [patient #10] choose to transfer to</p>		<p>discharge assessment of a patient onservice with the agency and the timeframe for the discharge assessment to becompleted in. 100% of the records have beenaudited with education provided to the nursing staff on deficiencies noted. Skilled care documentationwill be reviewed by the DON for compliance with a discharge assessment beingcompleted accurately and in the appropriate timeframe. 10% of the clinicalrecords will be audited quarterly for compliance. The DON will be responsiblefor monitoring these corrective actions to ensure this deficiency is correctedand will not recur.</p>				

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	<p>[other home health agency] from Incare. Effective transfer date 3/9/14. I understand the current home health agency will no longer provide Medicare provided services to me after the effective date of transfer. I request that my records be released to [the other home health agency] to ensure continuity of care. For agency use: Coordination of transfer: Phone call to [Employee J] date 3/10/14. Spoke with [Employee J], Beneficiary elected transfer form sent / faxed to current agency on 3/10/14." This form was completed by an employee of the other agency.</p> <p>B. On 3/12/14 at 9:15 AM, patient #10 indicated the Incare office staff have been calling her / him several times and because of the frequent phone calls patient has now decided to be discharged. This occurred around 3/9/14. Patient #10 indicated that the agency staff is aware that he / she wanted to be discharged and transferred to another agency. Transfer papers were signed.</p> <p>C. On 3/14/14 at 1:40 PM, Employee J indicated the patient had been transferred to the other agency and a discharge assessment had been completed.</p> <p>3. Clinical record #11 evidenced skilled nursing services had been provided 1 - 2 times a week for 1 week and 1 times a week for 8 weeks during the certification period 12/29/13 - 2/26/13 and 2 times a week for 1 week and 1 times a week for 8 weeks during the certification period of 2/27/14 - 4/27/14. The patient was discharged on 3/10/14. The record failed to include a discharge assessment.</p> <p>A. A document from another home health</p>			

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	<p>agency titled "Beneficiary elected transfer dated 3/9/14 and signed by the patient's caregiver stated, "I [patient #11 and caregiver's name] choose to transfer to [other home health agency] from Incare. Effective transfer date 3/9/14. I understand the current home health agency will no longer provide Medicare provided services to me after the effective date of transfer. I request that my records be released to [the other home health agency] to ensure continuity of care. For agency use: Coordination of transfer: Phone call to [Employee J] date 3/10/14. Spoke with [Employee J], Beneficiary elected transfer form sent / faxed to current agency on 3/10/14." This form had been completed by an employee of the other agency.</p> <p>B. On 3/12/14 at 9:17 AM, the caregiver of patient #11 indicated that patient #11 has requested a discharge from the agency and transfer to another agency. This occurred a few days ago on approximately 3/9/14. Transfer papers were signed.</p> <p>C. On 3/14/14 at 1:40 PM, Employee J indicated the patient had been transferred to the other agency and a discharge assessment had not been completed.</p> <p>4. The agency policy titled "Patient Discharge Process" with no effective date stated, "Planning for discharge is provided as part of the ongoing assessment of needs in accordance with expected care outcomes. The patient / family participate in this process beginning with the initial assessment. Patient's needs for continuing care to meet physical and psychological needs are identified and patients are told in a time manner of the need to plan for discharge or</p>			

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N000000	<p>transfer to another level of care / organization. 3. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan ... Documentation of all communication with the patient including rationale for discharge will be kept in the patient file with copies sent to the primary physician. Discharge criteria 1. Criteria for discharge ... a. the patient reached defined goals and is no longer in need of home care ... g. the patient chooses another home health care company ... 2. Agency will provide a discharge of the services to the patient, the patient's representative, or other individual responsible of the patient's care at least five days before services are stopped. The five day period does not apply ... the patient refuses home health agency's services ... The physician will order the patient to be transferred, as appropriate. 7. A discharge oasis will be completed as appropriate. Agency staff will complete a discharge summary."</p> <p>This was a home health state complaint investigation.</p> <p>Complaints: IN00145226 and IN00145297 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey Date: March 11 - 18, 2014</p> <p>Facility #: 7377</p>	N000000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	

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N000440	<p>Medicaid #: 200873250</p> <p>Surveyors: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor</p> <p>Skilled Patients: 116 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 28, 2014 410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>Based on document review and interview, the agency failed to ensure the organizational chart included speech therapy services for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. The agency's organizational chart, dated 2/19/09, failed to identify the agency had a speech therapist.</p>	N000440	Speech Therapy Services provided by St John Therapy Services per long-standing contract. It will be the administrator responsibility to ensure that the organizational chart is maintained current The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	04/17/2014
N000442	<p>410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall</p>			

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	<p>assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following:</p> <ol style="list-style-type: none"> <li>(1) Appoint a qualified administrator.</li> <li>(2) Adopt and periodically review written bylaws or an acceptable equivalent.</li> <li>(3) Oversee the management and fiscal affairs of the home health agency.</li> </ol> <p>Based on policy and administrative document review and interview, the agency failed to ensure that the governing body had appointed a qualified administrator, reviewed written by - laws, and oversaw the management and fiscal affairs of the agency for 1 of home health agency reviewed with the potential to affect all the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing indicated that the governing body had not had any meetings since 2012. Agency documents failed to evidence the governing body appointed a qualified administrator, reviewed written by - laws, and oversaw the management and fiscal affairs of the agency.</li> <li>2. A review of agency documents failed to show that the governing body had met in 2013 or 2014.</li> <li>3. On 3/17/14 at 11:15 AM, Employee A indicated the by - laws could not be found and there was no documentation showing the governing body appointed a qualified administrator, reviewed written by - laws, and oversaw the management and fiscal affairs of</li> </ol>	N000442	<p>TheGoverning Body meet on March 20,2014 and appointed Lisa Magura BSN, RN as the administrator and has delegated the authority and responsibilities for the provision of home care services inaccordance with state and federal regulations, accreditation standards and the agency mission. By laws have been adopted and reviewed. The POC has been appointed and has subsequently met on April 7, 2014. An annual operational budget and capital expenditure plan has been developed. The personnel,administrative, and patient policies and procedures were reviewed. The members of the Governing Body are: Jerry Fozzard Owner, Lisa Magura BSN RN Administrator. New members have been oriented to the GB and their respective duties. A roster of membership of the Governing Body has been implemented. The Governing Body will meet at least annually and as needed. The Administrator will act as the liaison between the Governing Body and the Professional Advisory Committee. Documentation in the form of GB</p>	04/17/2014

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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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N000448	<p>the agency.</p> <p>4. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. Special instructions The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibilities for the provision of home care services in accordance with state and federal regulations, accreditation stands, and agency mission. 2. Appoint the Professional Advisory Board ... as required by the state licensure and / or Medicare Conditions of Participation to guide the organization in the formulation and review of policies and procedures and ensure the highest quality of patient care 3. Adopt and periodically review and approve the administrative and personnel policies, patient care policies and procedures, by laws ... annual operating budget and capital expenditure plan. 4. Oversee the management and fiscal affairs of the agency." 410 IAC 17-12-1(c)(5) Home health agency administration/management Rule 12 Sec. 1(c)(5) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (5) Implement a budgeting and accounting system.</p> <p>Based on agency document review and</p>			N000448	<p>minutes of the Governing Body meeting will be done with each meeting and reviewed and signed. The Administrator and Governing Body will be responsible for monitoring of these corrective actions to ensure that this deficiency does not recur.</p> <p>Previous biller and administrator no longer with agency. Records reviewed by CEO and Medicare consultant Agency</p>		

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N000456	<p>interview, the home health agency failed to ensure the administrator implemented an effective budgeting and accounting system for 1 of 1 agency with the potential to affect all 116 active patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of agency documents failed to evidence the administrator had implemented an effective budgeting and accounting system.</li> <li>2. On 3/17/14 at 11, the 11:15 AM, the administrator / director of nursing indicated there is no documentation showing the administrator had implemented an effective budgeting and accounting system.</li> </ol> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following:</p> <ol style="list-style-type: none"> <li>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.</li> <li>(2) Resolve identified problems.</li> <li>(3) Improve patient care.</li> </ol> <p>Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings</p>	N000456	<p>administrator to maintain all financial records to effectively manage budget and accounting system. Administrator working on effective budget and accounting system and developing a financial team. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p> <p>A Quality Improvement Plan has been established by the Administrator and DON that includes performance improvement indicators with tools for collection of data, acceptable target percentage for each indicator, quarterly chart audit committee, chart audit tool and a process tool for identifying and resolving issues and unmet targets. A performance</p>		

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N000458	<p>1. On March 17, 2014, at 11:15 AM, the administrator indicated there had been no completed quality assurance program since 2012.</p> <p>2. A review of quality assurance documents evidenced the quality assurance program had not occurred since 2012.</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification,</p>		<p>improvement committee has been established.</p> <p>The Performance Improvement Committee will meet monthly and review all indicators for target goals and establish a plan of action for those targets that are not being met. The Chart audit committee will meet quarterly or more often and audit 10% of the clinical records to ensure compliance with all regulations regarding the clinical record and documentation there in.</p> <p>Administrator and DON will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>				

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	<p>or registration. (5) Annual performance evaluations.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure personnel files contained a signed job description, licenses, criminal history, annual evaluation, and orientation in 6 of 17 records reviewed (File A, F, H, I, K, O) of employees with the potential to affect all the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>Personnel file A, administrator / director of nursing, date of hire 12/30/13 and first patient contact 1/22/14, failed to evidence a signed job description for the administrator position.</li> <li>Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to show verification of occupational therapy license, criminal history verification, job description, and orientation.</li> <li>Personnel file H, registgered nurse (RN), date of hire 1/3/11 and unknown first patient contact, failed to evidence an annual evaluation since date of hire.</li> <li>Personnel file I, RN, date of hire 7/12/12 and first patient contact 7/14/12, failed to evidence an annual evaluation.</li> <li>Personnel file K, RN, date of hire 9/25/13 and first patient contact 1/23/13, failed to evidence a limited criminal history or expanded criminal history.</li> <li>Personnel file O, contract physical</li> </ol>	N000458	<p>All employee files to be audited for missing information. Missing physicals and Administrator job description were located in former alternate administrator's drawer in a mislabeled file. Documents placed in appropriate file. Physicals for RN A and C were performed prior to first patient contact. All missing nursing personnel TB testing located with physicals. Records were obtained for contracted (TRS)therapists F and O and found to be current. RN K is no longer employed with agency. Performance Evals for employee I to be presented to employee. Employee H is no longer employed with agency. Administrator conducted an audit of employee personnel files on March 25, 2014. On March 7, 2014, the administrator entered agreement with payroll company Paychex to audit and manage HR files, assist in developing formal orientation program and develop a more structured comprehensive employee manual. Administrator or designee will utilize employee checklist on all new employees and completeness will be checked by Administrator prior to first contact. All employees hired before March 2013will receive performance evaluation. Competencies will be checked by outside agency for HHAs. All file audit by HR designee and paychex. Administratorwill be</p>	04/17/2014

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	<p>therapist with unknown date of hire and first patient contact, failed to show verification of physical therapy license, criminal history, job description, and orientation.</p> <p>7. The agency policy titled "License, Registration, or Certification Requirements" with no effective date stated, "If a position requires licensure, registration, or certification, it shall be the employee's responsibility to keep these documents current ... a copy of the employee's currently license certification shall be maintained in his / her personnel file."</p> <p>8. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."</p> <p>9. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>10. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing, indicated the above files were incomplete.</p>		responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.		

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N000462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure personnel files contained a physical examination within 180 days of patient contact for 4 of 17 files reviewed with the potential to affect all the agency's patients and staff. (A, C, F, and O)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file A, administrator / director of nursing, date of hire 12/30/13 and first patient contact 1/22/14, failed to evidence a physical examination.</li> <li>2. Personnel file C, Registered Nurse (RN), date of hire 3/4/14 and first patient contact 3/4/14, failed to evidence a physical examination that showed the employee was free of communicable diseases.</li> <li>3. Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to evidence a physical examination.</li> </ol>	N000462	All personnel files have been audited for compliance with a physical within 180 days of first patient contact and a statement indicating that the employee is free of communicable diseases. A tracking tool is in place to monitor date of physicals, statement of free of communicable diseases and date of first patient contact. An audit tool has been instituted to ensure compliance with the need for a physical within 180 days of first patient contact and indicates that the employee is free of communicable diseases. Prior to first patient contact the Administrator or designee will audit the personnel file for compliance with this regulation prior the employee having patient contact. 10% of the personnel files will be audited quarterly for compliance with physicals less than 180 days of first patient contact. Administrator will be responsible for monitoring the corrective action to assure this deficiency is corrected and will	04/17/2014			

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	<p>4. Personnel file O, contract physical therapist with unknown date of hire and first patient contact, failed to evidence a physical examination.</p> <p>5. The agency policy titled "Health Screening" stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients. This includes, at a minimum, TB [tuberculosis] via the Mantoux method ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy ... On any employee or contract personnel providing direct patient care, there shall be documentation of completion of a tuberculin [TB] skin test, via the Mantoux method. OSHA requires two - step testing. If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within three weeks of the first test."</p> <p>6. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and</p>		not recur.	

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N000464	<p>result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>7. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing indicated the above files did not contain a physical examination. 410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis</p>			

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	<p>screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure personnel files contained an annual tuberculosis screening for 2 of 17 files reviewed with the potential to affect all the agency's patients and staff. (F and O)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to evidence annual tuberculosis screening.</li> <li>Personnel file O, contract physical therapist with unknown date of hire and first patient contact, failed to evidence annual tuberculosis screening.</li> <li>The agency policy titled "Health</li> </ol>	N000464	All personnel files have been audited for compliance with a TB screening/annual TB or two-step if indicated before first patient contact. A tracking system is in place to ensure annual TB screening is done using the mantoux, or CXR/health statement. The employees identified without annual TB screenings have been removed from patient contact until a screening is completed and/or proof of screening has been obtained. Prior to first patient contact the Administrator or designee will audit the personnel file for compliance with this regulation prior the employee having patient contact. 10% of the personnel files will be audited quarterly for compliance with annual TB screenings. An audit	04/17/2014

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	<p>Screening" stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients. This includes, at a minimum, TB [tuberculosis] via the Mantoux method ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy ... On any employee or contract personnel providing direct patient care, there shall be documentation of completion of a tuberculin [TB] skin test, via the Mantoux method. OSHA requires two - step testing. If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within three weeks of the first test."</p> <p>4. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>5. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing indicated the above files were incomplete.</p>		<p>tool has been developed to utilize in the auditing process. The Administrator will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>	

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N000470	<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 observation, interview, and professional standard review, the agency failed to ensure its staff had provided services in accordance to professional standards in 2 of 3 home visit observations (patient #6 and 7) completed creating the potential to affect any patients cared for by this registered nurse. (Employees E and I)</p> <p>The findings include</p> <p>1. On 3/13/14 at 3:30 PM, Employee E, home health aide, was observed to give a partial bath to patient #6. Employee E did not change gloves during the course of this bath despite changing the water in the basin before washing the peri area. She washed the patient's face, arms, chest, back, legs, feet, perineal area, anal area, and buttocks in that order without changing her gloves. She obtained a clean wash cloth for the peri care wash and changed the water before this time of the bath.</p> <p>a. On 3/14/14 at 4:20 PM, the administrator / director of nursing indicated the gloves should have been changed after washing the rectal area. She indicated she had given the agency procedure to the employee last week. She indicated that she would give this policy to the observer.</p>	N000470	Employee E re-educated on gloving during bathing according to Administrative Standards for the ISDH Nurse Aide Training Manual. Employee re-educated on Hand washing Technique per Policy D330 of Clinical Procedure Manual Home Health Aide staff re-in-service on Topic 17 Bathing, Procedure 33 bed bath and Procedure 2 gloves (Administrative Standards for the Indiana State Dept. of Health Nurse Aide Training Program). All nursing staff re-educated on Handwashing Procedure D330 of Clinical Procedure Manual. Administrator or designee observe Random hand washing and proper gloving by observing all home health aides and nurses. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.	04/17/2014

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N000472	<p>b. On 3/17/14 at 5:10 PM, the agency was unable to provide a procedure for giving a bath.</p> <p>2. On 3/17/14 at 2:40 PM at a home visit observation, Employee I, Registered Nurse, was observed to wash her hands prior to caring for Patient #7. She washed her hands with bar soap found in the patient's bathroom for 30 seconds and then dried with a paper towel.</p> <p>a. On 3/17/13 at 3:55 PM, the administrator / director of nursing indicated Employee I should not use bar soap for hand washing prior to patient care.</p> <p>b. A nursing procedure titled "Infection Prevention: Keeping it clean" with a date of March / April 2009 stated, "Wet your hands and wrists with warm water, and apply soap from a dispenser. Don't use bar soap because it allows cross-contamination. This was retrieved on 3/21/14 at 11 PM at <a href="http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf">http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf</a> 410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement</p>			

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N000494	<p>program must use objective measures.</p> <p>Based on agency policy and document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>On March 17, 2014, at 11:15 AM, the administrator indicated there had been no completed quality assurance program since 2012.</li> <li>A review of quality assurance documents evidenced the quality assurance program had not occurred since 2012.</li> </ol> <p>410 IAC 17-12-3(a)(1)&amp;(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</p>	N000472	<p>A Quality Improvement Plan has been established by the Administrator and DON that includes performance improvement indicators with tools for collection of data, acceptable target percentage for each indicator, quarterly chart audit committee, chart audit tool and a process tool for identifying and resolving issues and unmet targets. A performance improvement committee has been established. The Performance Improvement Committee will meet monthly and review all indicators for target goals and establish a plan of action for those targets that are not being met. The Chart audit committee will meet quarterly or more often and audit 10% of the clinical records to ensure compliance with all regulations regarding the clinical record and documentation there in. Administrator and DON will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>	04/17/2014

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	<p>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 agency document review, policy review, clinical record review, and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 2 of 12 clinical records reviewed with the potential to affect all the patients of the agency. (# 2, 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 2, start of care 2/19/14, failed to evidence the patient had been notified of the patient rights.</li> <li>2. Clinical record #9, start of care 12/11/13, failed to evidence the patient had been notified of the patient rights.</li> <li>3. On 3/18/14 at 10:45 AM, Employee A, the administrator / director of nursing indicated the documentation of the patient rights' acknowledgement was not in the records noted above.</li> <li>4. The agency policy titled "Home Care Bill of Rights / Grievance procedure" with no effective date stated, "Patients will be informed of their right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Agency will provide a mechanism in which a patient's complaint can be processed</li> </ol>	N000494	<p>Administrator has In-serviced nursing staff on Patient Rights. Patients re-educated and received Patients' Rights and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and responsibilities and a copy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited. Administrator to audit 10% of existing patient charts weekly for compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	04/17/2014

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N000514	<p>and resolved promptly and efficiently ... To protect and promote the exercise of patient's rights."</p> <p>5. The agency document titled "Patient bill of rights and responsibilities" with no effective date stated, "The Patient or 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 as follows: the home health agency shall provide the patient with a written notice of the patient rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. the home health agency shall maintain documentation showing that it has complied with the requirements of this section."</p> <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 policy review, clinical record review, administrative document review, and interview, the agency failed to follow their</p>	N000514	All staff have been instructed on the policy and process forreceiving, documenting and resolving patient grievances. Staff has beeninstructed on the use of				

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	<p>own policy to investigate complaints and document the existence and resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</li> <li>2. The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities."</li> <li>3. Clinical record #12, start of care 10/23/13, evidenced the patient had received the patient rights at the start of care.</li> <li>4. On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed a complaint due to lack of requested toenail care and also lack of home health aide services as had been planned with care planning. Patient #12 had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</li> <li>5. On 3/14/14 at 2:45 PM, the administrator</li> </ol>		<p>the complaint log, patient grievance form and that all patient grievances or concerns are to be brought to the attention of the DON and/or the Administrator in a timely manner for follow up, investigation and resolution. Staff will be in-serviced on hire, annually and as necessary on the right of patient to have grievances acknowledged and fully investigated and informed of the resolution of their grievance as outlined in the Grievance Policy. The DON and/or the administrator will review all grievances and ensure that investigation, resolution and documentation take place. The DON and the Administrator will be responsible for monitoring and ensuring that this deficiency does not recur.</p>		

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N000518	<p>indicated the complaint had not been filed in the complaint log.</p> <p>6. A review of the complaint log and other agency documentation failed to evidence any investigation or other documentation concerning the complaint filed by patient #12. 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, observation, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced directives, including a description of applicable State law, in 12 of 12 records reviewed (#1 - 12) with the potential to affect all the active patients of the agency.</p> <p>Findings include</p> <p>1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. On 3/14/14 at 2 PM, the administrator / director of nursing indicated the advanced</p>	N000518	<p>All chart are being audited for deficient practices. Administrator re-educated nursing staff on Patient Rights. Patients re-educated and received Patients' Rights and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and responsibilities and a copy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited. Administrator to audit 10% of existing patient charts weekly for compliance. Administrator will be responsible</p>	

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	<p>directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patients #5, #6, #7 home admission books and that all the patients of the agency needed to receive the updated advanced directives.</p> <p>3. Clinical record #1, SOC 1/17/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record #2, SOC 12/11/13 failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. There was no evidence in the record that the patient had received the patient rights.</p> <p>5. Clinical record #3, SOC 10/24/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record #4, SOC 10/21/10, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record #5, SOC 12/30/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 11 AM, the home admission book was observed in the home for patient #5. The book did not contain the Indiana Advanced Directives effective May 2004 and</p>		for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.	

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	<p>revised July 1, 2013.</p> <p>8. Clinical record #6, SOC 11/2/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 3:30 PM, the home admission book was observed in the home for patient #6. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>9. Clinical record #7, SOC 7/26/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/17/14 at 1:10 PM, the home admission book was observed in the home for patient #7. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>10. Clinical record #8, SOC 11/7/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had signed that the document was received on the SOC date.</p> <p>11. Clinical record #9, SOC 11/7/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had not received the patient rights.</p> <p>12. Clinical record #10, SOC 5/3/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the</p>			

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N000520	<p>document was received on the SOC date.</p> <p>13. Clinical record #11, SOC 2/27/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #12, SOC 10/23/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on policy review, clinical record review, administrative document review, and interview, the agency failed to meet the needs of 1 of 12 clinical records reviewed ( #2) with the potential to affect any patient of the agency.</p> <p>Findings include</p> <p>1. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13 and failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14 or the current certification period that has unknown dates. The patient is still an active patient and filed a complaint due to the lack of home health aide services needed and the lack of a podiatrist's care</p>	N000520	The Administrator has provided education to the Clinical Intake coordinator (who collects the initial patient information and referral)and the RN case managers (who provide the initial evaluation and assessment for home care needs, medical necessity and homebound status) on the CoP and policies concerning the admission of patients who the agency can provide the scope of service that the patient needs. Instructed to identify the scope of service needs and ensure that those needs can be met by the agency. Instructed to discuss any concerns about meeting the scope of service with the DON and/or the Administrator. 100% of	

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	<p>despite an order for this. There was no documentation in the record that the patient received care from a podiatrist. There were no aide visits noted in the record. The patient had signed receiving the patient rights at the start of care.</p> <p>a. A clinical record document titled "Fax" and a date of 11/21/13 stated, "Patient to see podiatrist." This was signed by the physician and Employee I, RN.</p> <p>b. On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed a complaint due to lack of requested toe nail care and also lack of home health aide services as had been planned with care planning. Patient #12 indicated the patient had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</p> <p>c. A review of the complaint log failed to evidence this complaint.</p> <p>d. On 3/14/14 at 2:45 PM, the administrator indicated the complaint had not been filed in the complaint log and the plan of care was not in the record for recertification periods and indicated no documentation was present about the home health aide services or lack of a podiatrist visit.</p> <p>e. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patent has the right to place a complaint with the</p>		<p>the clinical records have been audited to determinethat all patient needs are being met as ordered. A Podiatrist has been securedto see the patient. Aide services are available and have been scheduled for the patient. The option of transferring to another homecare was offered and declined. All staff have been instructed on the policy and process forreceiving, documenting and resolving patient grievances. Staff has beeninstructed on the use of the complaint log, patient grievance form and that allpatient grievances or concerns are to be brought to the attention of the DONand/or the Administrator in a timely manner for follow up, investigation andresolution. Staff will be in-serviced on hire, annually and as necessary on the right of patient to have grievances acknowledged and fully investigated and informed of the resolution of their grievance as outlined in the Grievance Policy. The DON and/or the administrator will review all grievances and ensure that investigation, resolution and documentation take place. The DON will revieweach referral for appropriateness for admission and determine that the scope of service needs can be met. Case conferences will be regularly scheduled to determine and discuss on going patient needs and that needs are being met and</p>	

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N000522	<p>department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</p> <p>2. The agency policy titled "Patient Admission Process" with no effective date stated, "If the agency cannot fulfill the required health need, a referral will be made to other appropriate community resources and referral source will be notified."</p> <p>3. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs." 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 clinical record and agency policy review, observation, and interview, the agency failed to ensure treatments and services had been provided in accordance with physician's orders in 7 of 12 records (2, 3, 4, 7, 8, 9, 12) reviewed creating the potential to affect all of the agency's 116 active patients.</p>	N000522	<p>appropriate referrals are being done. 10% of the clinical records will be reviewed quarterly to ensure that the patient scope of service needs are being met. The DON or designee will be responsible for the monitoring of the correction plan to ensure that this deficiency does not recur.</p> <p>All active charts audited for deficient practices. 5 RNs (84%) of skilled nursing staff are no longer with agency. (1) Nurses educated/re-educated on components of nursing assessment and following plan of care, (policy D145). All new SOC documents submitted are reviewed for accuracy. Skilled nurses re-educated on patient</p>	

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	<p><b>Findings</b></p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse oximetry every visit. The record failed to evidence the skilled nurse performed these tasks.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a</p>		<p>assessment, following physician orders and teaching. (2) Nurses re-educated on pain assessment,interventions and documentation (policy C148). (3) Nurse J no longer employed with agency. (4) Nurse I re-educated on following physicians orders, the plan of care, care coordination and frequency compliance. Nurse I counselled on obtaining weights as ordered. (4) All charts audited for presence of therapy orders, glucose monitoring and frequencies. Physician notified of any discrepancies identified. Charts audited for frequencies and physician notified if discrepancies were identified. Staff educated on following the ordered frequency. (5) Nurse G is no longer employed with agency.All patient charts were audited for wounds and for appropriate orders and documentation. (6) Charts were audited for presence of plan of care. Office staff educated on filing plan of care immediately and process initiated for timely printing of all documents. Administrator or designee will audit 10% of patient charts weekly for presence and adherence to the plan of care and documentation supporting the plan of care is being followed. Audits will include monitoring for the completion of assessments, pain assessment and interventions,skin care, treatments, presence of wounds,</p>				

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	<p>plan of care for the certification period of 2/2/14 - 4/4/14 and evidenced the plan of care was not followed.</p> <p>a. This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks and the home health aide (HHA) was to visit 1 - 2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26 and HHA visits on 2/5/14. There were no other SN and HHA visits in the record.</p> <p>b. Additionally, this plan of care included orders for the skilled nurse to give Vitamin B12 1000 mcg per ml monthly subcutaneous. This medication was documented as being given in the antecubital space on February 26, 2014, by Employee J, registered nurse (RN). It was not documented if this was given as an intramuscular injection or subcutaneous injection.</p> <p>c. Via telephone call, on 3/14/14 at 12:30 PM, Patient #4 indicated that the registered nurse, Employee J, had given the Vitamin B 12 injection into the upper left arm at the last visit.</p> <p>d. On 3/14 2:20 PM, the administrator / director of nursing indicated the Vitamin B12 injection was to be given subcutaneous and this was not documented and did not follow the plan of care. Employee A indicated the nurse had written in error that the injection had been given into the antecubital space.</p> <p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p>		<p>wound assessments, wound care, weights, glucose monitoring and monitoring frequencies being followed. Transition to Axxess EMR integrates a comprehensive detailed nursing assessment. Staff educated on orders to be followed at all times and physician notification for any discrepancies or changes in the patient's condition. Therapy log initiated to track orders, notification and visits. Office staff oriented to SOC audits and weekly audits to monitor frequencies. All scheduling and documentation requirements are to be transitioned to Axxess which immediately flags missed visits or frequency discrepancies. All staff educated on policies; Medical Supervision, Scope of Practice and Plan of Care. Nurse's inserviced on the risks and consequences of not following the physician ordered plan of care. An additional nurse with previous homecare experience is employed in office. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p>				

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	<p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>4. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 with orders for physical therapy and occupational therapy, and no orders for glucose testing.</p> <p>a. The plan of care for the certification period of 11/7/13 - 1/5/14 evidenced that the patient was to receive physical therapy 1 - 2 times a week for 5 weeks and Occupational therapy visits 1 - 2 times a week for 5 weeks. No visits were made.</p> <p>b. The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>c. On 3/14/14 at 3:18 PM, the administrator / director of nursing indicated the above visits and lack of visits did not follow the plan of care.</p> <p>5. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a</p>			

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	<p>plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance, assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p> <p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p> <p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>6. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a</p>			

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	<p>plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, the administrator / director of nursing indicated the plan of care was not in the record for this certification period.</p> <p>7. The agency policy titled "Medical Supervision" with no effective date stated, "A physician plan of care is developed for each patient at the time of admission and signed by the physician in the appropriate time frame ... agency responsibilities include prompt reporting of a change in patient condition ... support of a physician plan of care."</p> <p>8. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p> <p>9. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An</p>			

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N000524	<p>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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."</p> <p>10. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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.</p>			

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	<p>(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> <p>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements for 9 of 12 records reviewed (#1, #2, #3, #4, #6, #7, #8, #9, #12) with skilled nursing with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, primary diagnosis of Osteoarthritis and start of care (SOC) date 1/17/14, contained a plan of care (POC) for 1/17/14 - 3/17/14 that stated, "Care by 3/17/14." There were no measurable goals or outcomes for this patient.</p> <p>On 3/14/14 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the goals on the plan of care were not measurable.</p> <p>2. Clinical record #2, primary diagnosis of asthma and SOC date 12/11/13, contained a POC for 12/11/13 - 2/8/14 with orders for skilled nurse visits 1 - 2 times a week for 9 weeks. There were no measurable goals or outcomes for this patient. The physician's signature on this POC was dated 1/14/14.</p> <p>On 3/14/14 at 3:50 PM, Employee A indicted the goals on this plan of care were not</p>	N000524	All charts audited for the deficient practices. 84% of nurses nolonger employed with agency and 100%office staff no longer with agency.(1,2)All patients identified with incomplete plan of care documentation wereclarified with physician, completed and appropriately submitted to the patientsphysician. (4,7)Nurses educated on mandatory requirement of signing plan ofcare and submitting within 48 hours of completion of assessment. (5) Nurseseducated on mandatory requirement of obtaining and adhering to physician ordered frequencies. Education to RN case mangers provided on the need to establish anddocument measurable goals on the POC. A fax log and tracking system of checkingfor returned signed POC and verbal orders established; education provided toprofessional staff on the need for physician orders for all care and treatmentsto be provided to the patient. (6) Nurses educated on completing plan of carein entirety and list any and all DME and equipment. (8) Nurse identified forthis patient is no longer	04/17/2014			

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	<p>measurable.</p> <p>3. Clinical record #3, primary diagnosis of Alzheimer's disease and SOC date of 10/24/13, contained a POC for 12/23/13 - 2/20/14 with orders for skilled nurse visits 1 - 2 times a week. The POC failed to evidence a timely signature of the physician with a physician's signature on 2/4/14. The skilled nurse had not signed the verbal order in box 23 of this POC. This POC lacked measurable goals.</p> <p>On 3/14/14 at 1:57 PM, Employee A indicated the registered nurse had not signed the POC and the physician had not signed the POC and the goals on the POC were not measurable.</p> <p>4. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 4/2/14 that failed to evidence a nurse's signature and date of verbal order and a physician's signature.</p> <p>On 3/11/14 at 4:35 PM, Employee A indicated the POC failed to include a doctor's signature or nurse's signature.</p> <p>5. Clinical record #6, SOC 11/2/13 and primary diagnosis of pressure ulcer stage 1, included a plan of care for the certification period of 3/2/14 - 4/30/14 that failed to evidence the frequency and duration of the home health aide (HHA) and skilled nurse (SN) visits. SN visits occurred on 3/4/14 and the HHA visits occurred on 3/1/14, 3/4/14, 3/6/14 and 3/13/14.</p> <p>On 3/14/14 at 2 PM, Employee A, administrator and director of nursing,</p>		<p>employed with agency. (9) Nursing educated regarding the requirement of an active plan of care in order to provide services for patient. The DON/Alternate DON or nursing designee will audit 10% of charts weekly to ensure completion of plan of care, and that it is appropriate for patient. The DON/Alternate DON or nursing designee will monitor all patient start of care and re-certifications for appropriate, complete and timely submission of the plan of care. All plan of cares will be monitored to include appropriate signatures and dates. The DON/Alternate DON or nursing designee will monitor all scheduling and clinical documentation to be in compliance with the frequencies noted on the plan of care. Axxess system transition will provide numerous auditing and tracking systems and submissions will be more timely as it is electronic. The DON/Alternate DON or nursing designee will be responsible for monitoring these corrective actions and will be reviewed at quarterly to ensure the deficiency is corrected and will not recur.</p>				

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	<p>indicated the frequency and duration of skilled nurse and HHA visits were not on the plan of care.</p> <p>6. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, that failed to evidence the patient had a wheelchair and walker.</p> <p>a. On 3/17/14 at 1:10 PM, it was observed that the patient had a wheelchair and walker.</p> <p>b. On 3/18/13 at 3:55 PM, Employee A indicated the plan of care was not complete.</p> <p>7. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 that failed to evidence a nursing signature with the verbal order or a physician order for this plan of care.</p> <p>On 3/14/14 at 3:18 PM, Employee A, administrator, failed to evidence a physician's signature or verbal order to start care.</p> <p>8. Clinical record #9, start of care (SOC) 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included wound care but the plan of care did not specify the type of wound care to be provided.</p> <p>9. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made</p>			

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N000527	<p>visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, Employee A indicated the plan of care was not in the record for this certification period.</p> <p>10. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of car 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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care." 410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to</p>				

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	<p>alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint</p>	N000527	The Administrator/DON have conducted in-services with allnursing staff to address the regulations, policies and procedures on followingthe established plan of care, evaluating and re-evaluating the patient'son-going needs and notifying the physician in any change in patient conditionand needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes inpatient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these correctiveactions to ensure this deficiency is corrected and will not recur.	04/17/2014			

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N000532	<p>and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician.</p> <p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and</p>	N000532	Patient charts audited for changes in condition, abnormal assessment, pain level and physician notification. Nurse J and patient #4 are no longer with agency. Nursing staff educated on peripheral circulation, foot assessment and notification and documentation of change in condition. Nurses educated on pain assessment, intervention and appropriate notification of pain levels out of patients established acceptable range (policy C148). Administrator or designee to audit 10% of patient charts weekly for documentation of		

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N000537	<p>to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical</p>		<p>abnormal assessment, change in condition, pain and physician notification/orders. Administrator to provide additional training for nurses related to pain management. All clinical documentation entered in Axxess requires QA approval in order to be submitted. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p>				

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	<p>nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services had been provided by the registered nurse with physician's orders in 6 of 12 records (2, 3, 4, 7, 8, 9) reviewed creating the potential to affect all of the agency's 116 active patients.</p> <p>Findings</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse oximetry every visit. The record failed to evidence the skilled nurse performed these tasks at the initial assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician</p>	N000537	<p>All active charts audited for deficient practices. 5 RNs (84%) of skilled nursing staff are no longer with agency. (1)Nurses educated/re-educated on components of nursing assessment and following plan of care, (policy D145). All new SOC documents submitted are reviewed for accuracy.Skilled nurses re-educated/inserviced on patient assessment, following physicians orders and patient education. (2) Nurses inserviced on pain assessment, interventions and documentation (policy C148). (3) Nurse J no longer employed with agency. (4) Nurse I re-educated on following physicians orders, the plan of care, care coordination and frequency compliance. (4) All charts audited for presence of therapy orders, glucose monitoring and frequencies. Physician notified of any discrepancies identified. Charts audited for frequencies and physician notified if discrepancies were identified. Staff educated on following the ordered frequency. (5) Nurse G is no longer employed with agency.All patient charts were audited for wounds and audited for appropriate orders and documentation. (6) Charts were audited for presence of plan of care. Office staff educated on filing plan of care immediately and process initiated</p>	04/17/2014			

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	<p>for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 2/4/14 and evidenced the plan of care was not followed.</p> <p>This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26/14. There were no other SN visits in the record.</p> <p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p> <p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>5. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of</p>		<p>for timely printing of all documents. Administrator or designee will audit 10% of patient charts weekly for presence of the plan of care and documentation the plan of care is being followed. Audits include monitoring for the completion of assessments, pain assessment and interventions, skin care, treatments, presence of wounds, wound assessments, wound care, weights, glucose monitoring and monitoring that frequencies are being followed. Transition to Axxess EMR integrates a comprehensive detailed nursing assessment. Staff educated on orders to be followed at all times and physician notification for any discrepancies or changes in the patient's condition. Therapy log initiated to track orders, notifications and visits. Office staff oriented to SOC packet contents and weekly audits to monitor frequencies. All scheduling and documentation requirements are to be transitioned to Axxess flags frequency discrepancies. All staff educated on policies; Medical Supervision, Scope of Practice and Plan of Care. Nurse's inserviced on the risks and consequences of not following the physician ordered plan of care. A nurse with previous homecare experience is hired for office to assist in ensuring services are provided as ordered and monitoring compliance. The</p>		

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	<p>11/7/13 - 1/5/14 that failed to evidence orders for glucose testing.</p> <p>The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>6. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance, assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p> <p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p>		<p>administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p>	

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	<p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>7. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p> <p>8. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... 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 ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders</p>			

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N000540	<p>will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."</p> <p>9. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed the initial assessment visit to determine the immediate care and support needs of the patients for 1 of 12 records reviewed (1) with the potential to affect all new patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. The initial assessment was not completed. There was no referral date in the record.</p> <p>2. On 3/14/13 at 2:35 PM, Employee A, the</p>	N000540	All charts audited for initial assessments and and missing information including referral dates. Staff educated on completing all documentation in its entirety and not omitting date. Employee responsible to completion of initial assessment no longer with agency. Administrator or designee will monitor completeness of all pre-admit documentation on a weekly basis. Pre-admission audit tool to be implemented. The administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency		

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N000542	<p>administrator / director of nursing, indicated the initial assessment was not in the record. 410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a)(1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's need at least every 60 days for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days. (#2 and #4).</p> <p>Findings include:</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 and 2/9/14 - 4/9/14. The record failed to evidence the registered nurse completed a comprehensive recertification assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>2. Clinical record #6, SOC 11/2/13, included plans of care for the certification periods of 1/1/14 - 3/1/14 and 3/2/14 - 4/30/14. The record failed to evidence the registered nurse had completed a comprehensive recertification assessment.</p>	N000542	<p>is corrected and will not recur</p> <p>All charts audited for the presence of timely re-assessments. Office staff re-educated on filing re-certification and documentation timely. If assessment has been completed in Genie system, it is to be printed and filed timely. Employee responsible for notifying staff of re-certifications due and filing of assessments is no longer employed at agency. Nurses have been re-educated on re-certification timelines and timely submission of documentation. 5 of the nurses responsible are no longer with agency. Administrator will monitor the completion of re-assessments by using a re-certification list and checking on a weekly basis. Administrator or designee to schedule all skilled visits including re-certification assessments in Axxess. Scheduled tasks appear on the screen with the appropriate assessment forms selected. Additional nursing staff hired to prevent this deficient practice from recurring. The</p>		

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N000546	<p>On 3/14/14 at 2:10 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse promptly alerted the physician to changes in the patient's condition for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p>	N000546	<p>administrator or designee will be responsible for monitoring these corrective actions and will be reviewed at each quarterly meeting to ensure the deficiency is corrected and will not recur.</p> <p>The Administrator/DON have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted.</p>	

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N000550	<p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician.</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p>	N000550	<p>Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance.</p> <p>The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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	<p>Based on clinical record review and interview, the agency failed to ensure the home health aide care plan was updated in 2 of 8 records reviewed of patients receiving aide services (3 and 7) creating the potential to affect patients with aide services.</p> <p>Findings</p> <p>1. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care (SOC)10/24/13, contained a plan of care for 12/23/13 - 2/20/14 with orders for home health aide visits 1 - 2 times a week for 9 weeks. The aide care plan had not been updated since 10/24/13. Aide visits were made on 2/3/14, 2/7/14, 2/10/14, 2/13/14, and 2/17/14.</p> <p>On 3/14/14 at 1:56 PM, Employee A, administrator / director of nursing, indicated the aide care plan had not been updated every 60 days.</p> <p>2. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, contained a plan of care for 12/21/13 - 3/22/14 with orders for skilled nursing once a week and for home health aide visits (the frequency and duration was not ordered). The aide care plan had not been updated since 7/26/13. Home health aide visits were made on 12/23/13, 12/29/13, 12/31/13, 1/4/14, 1/7/14, 1/14/14, 1/18/14, 1/21/14, 1/25/14, and 1/28/14.</p> <p>On 3/18/14 at 11 AM, Employee A indicated the aide care plan had not been updated since 7/26/13.</p>		<p>have been audited for completion and compliance with review by the RN at minimum every 60 days. The professional RN staff has been educated on the necessity of updating the home health aide care plan at least every 60 days and when necessary based on a change in patient need/condition.</p> <p>The DON or designee will audit each SOC and recertification for a home health aide care plan and necessary review and updates. 10% of the clinical records will be audited every quarter for compliance with 60-day updates and review of the home health aide care plan.</p> <p>The DON/Alternate DON will be responsible for monitoring these corrective actions and is responsible for ensuring this deficiency does not recur.</p>				

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(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	
N000604	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on observation , clinical record review, and interview, the agency failed to ensure the home health aide reported changes observed to the supervisory nurse for 1 of 1 observation of a home health aide (Employee E) with the potential to affect all patients receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/13/14 at 3:30 PM, Employee E, home health aide, was observed to give a partial bath to patient #6. The patient had two small open areas in the patient's groin area. After the bath, the caregiver at the home applied ammonium lactate lotion that had been ordered by the physician. The patient complained of pain when this topical medication was applied. This record failed to evidence the aide had reported the open areas to the nurse.</li> <li>On 3/14/14 at 4 PM, Employee E indicated not updating the nurse about the discomfort the patient had at the visit on 3/13/14 or the new open areas on the patient's groin area.</li> </ol>	N000604	<p>The Administrator and DON have conducted in-services with all home health aides for the need to report any changes in patient condition to the RN case manager upon discovery of that change and the required documentation. The aide involved with the cited incident has had additional education and counseling. The DON has in-service all nursing case managers on the need to inform the physician of any significant change in patient condition and follow up with any further orders related to that condition change.</p> <p>100% of the clinical records have been audited for compliance with notifying the physician of change in patient condition and needs. At the supervisory visits the communication logs will also be monitored for any documented change in condition. Administrator will be responsible for monitoring the corrective action to assure</p>	04/17/2014	

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every 30 days in 1 of 8 records reviewed of patients (#5) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services.</p> <p>Findings</p> <p>1. Clinical record #5 evidenced home health aide services had been provided 1- 2 times a week for 9 weeks during the certification period of 12/30/13 - 2/27/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 12/30/13 - 2/27/14 by the registered nurse.</p> <p>2. On 3/14/14 at 3:20 PM, the administrator / director of nursing indicated the aide supervision had not occurred at the for the time period identified.</p>			N000606	<p>this deficiency is corrected and will not recur.</p> <p><b>All chart are being audited for deficient practices. Majority of nurses assigned to patient have been replaced, Nurses were re-educated on the policy Home Health Aide Supervision. 84% of nursing no longer with agency . Nurses were re-educated on policy of aide careplan, updates and reviews Administrator or designee will monitor 10% of charts weekly for aide supervision. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p>		
N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records</p>						

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	<p>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.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(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.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to maintain clinical records in accordance with its own policy in 3 of 12 records reviewed (1, 3, 4) creating the potential to affect all of the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 1/17/1 and primary diagnosis of Osteoarthritis, included a plan of care for the certification period of 1/17/14 - 3/17/14. There was no initial assessment in the record at this time. The initial assessment was found outside of the record on 3/14/14.</p> <p>On 3/14/14 at 2:35 PM, the administrator / director of nursing indicated the clinical record had missing documentation.</p>	N000608	<p><b>Administrator and designee have gone through all drawers and cabinets in agency and all medical records were placed in appropriate area/chart/file. All faxing and filing to be done in a timely manner and not to be placed in inappropriate areas. Administrator or designee to monitor cubicles two times weekly for documents for filing and monitor that fax confirmations are attached to orders. Monitor that there is always a copy of documents in patients chart if awaiting a signature. Transition to Axxess to reduce paper filing.</b></p> <p><b>Administrator or designee will be responsible for monitoring these corrective actions and</b></p>	04/17/2014			

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	<p>2. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care 10/24/13, contained plans of care for 12/23/13 - 2/20/14 and 2/21/14 - 2/21/14. The record failed to evidence a recertification assessment when the record was reviewed on 3/12/14.</p> <p>On 3/14/14 at 1:55 PM, the administrator / director of nursing indicated the recertification for 2/17/14 had not been present in the record and was found and placed in the record. This document should have been placed in the record in a timely manner.</p> <p>2. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, failed to evidence a start of care assessment and medication profile.</p> <p>On 3/14/14 at 2:20 PM, Employee J indicated the SOC assessment and medication profile were missing from the record.</p> <p>3. The agency policy titled "Clinical records / Medical Record Retention" and no effective date stated, " Clinical record [is] A confidential clinical record containing pertinent past and current findings in accordance with professional standards is maintained for every patient receiving home health services."</p>		<b>will be reviewed each quarterly qualitymeeting to ensure this deficiency does not recur.</b>		