

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2016
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NAME OF PROVIDER OR SUPPLIER HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
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G 0000 Bldg. 00	<p>This was a federal home health recertification survey. This was an extended survey.</p> <p>Survey Dates: June 28, 29, 30, and July 6 and 7, 2016 Parital Extended Dates: June 29, 2016 Extended Dates: June 30, July 6 and 7, 2016</p> <p>Facility Number: 004219</p> <p>Medicaid Number: 200889890B</p> <p>Census Service Type: Skilled: 36 Home Health Aide Only: 1 Personal Care Only: 0 Total: 37</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Homepointe Healthcare is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 7, 2016 thru July 7, 2018 for being</p>	G 0000	<p>HomePointe HealthCare (HPHC) acknowledges that a survey was completed by representative from the Indiana State Department of Health on June 28, 29, 30 and July 6, 7 of 2016 HPHC recognizes that we are precluded from providing our own home health aide training and competency evaluation program for a period of 2 years beginning July 7, 2016 through July 7, 2018. We currently do not have home health aide clients because we are primarily a pediatric extended care agency Prior to admitting a home health aide case, HPHC will contract with an outside Registered Nurse to preform the competency training and evaluation of individuals hired.</p>	
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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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G 0120 Bldg. 00	<p>found out of compliance with the Conditions of Participation 42 CFR 484.30 Skilled Nursing Services; and 484.48: Clinical Records.</p> <p>484.12(b) DISCLOSURE OF OWNERSHIP & MANAGEMENT The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management:</p> <p>(1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§420.201,420.202, and 420.206 of this chapter.</p> <p>(2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter.</p> <p>(3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation,</p>			

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	<p>association, or other company responsible for the management of the HHA. Based on document review and interview, the agency failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The ISDH pre-survey report dated 6/13/16 listed previous employee AA as the Alternate Nursing Supervisor. 2. During interview on 6/28/16 at 11:05 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor left the agency in April, the position is currently vacant but employee D (Assistant Clinical Manager) will be taking that role once she takes her Registered Nurse licensure exam this summer. 3. During interview on 6/28/16 at 11:05 AM, employee A stated he did not think the ISDH had been notified of the change yet, and that the acting Alternate Nursing Supervisor would be employee C (Alternate Administrator). 4. During interview on 6/29/16 at 11:05 AM, the Administrator stated employee C is the acting Alternate Nursing 	G 0120	This deficiency was corrected on 6/30/16, the Agency Staff Notification Form was completed and fax with additional required documents to the ISDH Awaiting confirmation The Administrator will ensure that the state is notified of any changes upon resignation/termination of the Administrator or Director of Nursing and their alternates	07/08/2016

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G 0121 Bldg. 00	<p>Supervisor.</p> <p>5. During interview on 6/29/16 at 11:07 AM, employee C stated they just realized yesterday that the ISDH was not notified that the previous Alternate Nursing Supervisor left in April, so the agency sent a notification.</p> <p>6. On 6/28/16 at 2:01 PM, ISDH an email was received back from ISDH Program Secretary and stated "I don't have any record of staff changes from this facility."</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, document review and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 5 home visits (patient # 4).</p> <p>Findings include</p>	G 0121	The Director has in serviced all staff members on 7/22/16. The in service included an informational packet from the WHO titled Hand Hygiene Why, Howand When. This includes instructional material on hand and glovehygiene procedures. HPHC's Hand and Glove Hygiene Competency Evaluationhas been updated to	07/22/2016

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	<p>1. During home visit on 6/30/16 at 11:00 AM with patient #4, employee I (Registered Nurse) was observed providing G button care, dressing patient, shaving patient and brushing patient's teeth. Employee I failed to wash hands after removing gloves, and failed to wash hands for longer than 3-7 seconds.</p> <p>A. After employee I shaved patient's face, she removed her gloves and washed hands for 3 seconds. Employee I failed to wash hands longer than 3 seconds.</p> <p>B. After brushing patient's teeth, employee I removed her gloves, then donned new gloves. Employee I failed to wash her hands or use hand sanitizer in between glove changes.</p> <p>C. Employee I applied cream to patient's skin on face, removed her gloves, then donned new gloves. Employee I failed to wash her hands or use hand sanitizer in between glove changes.</p> <p>D. After brushing patient's teeth, employee I rinsed the tooth brush, then washed her hands for 7 seconds. Employee I failed to wash hands longer than 7 seconds.</p> <p>2. During interview on 7/6/16 at 9:45</p>		<p>include hand hygiene duration and glove hygiene procedures The Clinical Care Manager/Director will monitor staff's adherence/ compliance through home supervisory visits on each client a minimum of every 60 days during supervisory visits. During orientation and annually, staff will demonstrate competency for hand and glove hygiene</p>	

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	<p>AM, employee A (Nursing Supervisor) stated staff should be singing the ABC's while washing hands, or at least washing hands for 30 seconds, and employees should be washing hands in between glove changes.</p> <p>3. The agency's policy titled "Handwashing," no number, revised 08/06/14 stated "Procedure: ... G. Hands should be rubbed vigorously during washing for at least 30 seconds with special attention paid to the backs and fingertips."</p> <p>4. The agency's procedure titled "How to Handwash?" stated "Wash hands when visibly soiled! Otherwise, use handrub ... Duration of the entire procedure: 40-60 seconds."</p> <p>5. The agency's policy titled "Infection Prevention," # B-403, effective date 07/01/07 stated "Standard Precautions-Tier One ... B. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganism between other clients or the environment."</p>			

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G 0133 Bldg. 00	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 2 of 7 employee files reviewed (C and N); failed to ensure the Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency; and failed to ensure the Quality Assurance Report included OASIS submission and errors review, and failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency.</p> <p>Findings include</p> <p>1. Employee files were reviewed on 7/7/16. Employee file C (Alternate Administrator), date of hire 2/13/13, failed to contain a job description.</p> <p>A. During interview on 7/7/16 at 11:55 AM, the Administrator stated she could not find the job description.</p>	G 0133	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present and notify ISDH regarding appropriate administrative changes.</p> <p>All personnel files will be audited a minimum of annually.</p> <p>The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency.</p> <p>HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files. Hobart OASIS data entry person has begun to communicate (call/email) with the Fort Wayne office when OASIS error messages occur.</p> <p>The Fort Wayne office will keep</p>	07/11/2016

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	<p>2. Employee file N (home health aide), date of hire 1/8/10, first patient contact date 7/1/10, failed to contain a copy of the Home Health Aide competency test.</p> <p>3. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list.</p> <p>4. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... Orientation sheets Signed Job Description."</p> <p>5. The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects, and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p>		<p>a log of this communication for QA. The error messages will be investigated and corrected as needed. Director is responsible for pulling OASIS submission and final validation reports. The Director is also responsible for pulling Potential Avoidable Event, error and additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. The Director will be responsible for monitoring trends and initiating action plans as necessary. This has begun in the month of July.</p>	

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	<p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p> <p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p> <p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p>			

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	<p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p> <p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors but they do not document this communication; and the Administrator stated the Fort Wayne office had not seen error reports.</p> <p>6. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the agency reviewed OASIS submission and final validation reports.</p> <p>7. The agency's policy titled "Performance Improvement," # B-260, effective date 07/01/07, stated "Procedure A. ... Program will reflect participation by all services and levels of staff; and will subscribe to compliance with internal and external standards including</p>			

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	<p>the Medicare Conditions of Participation.</p> <p>... E. Data will be assessed to:</p> <ol style="list-style-type: none"> 1. Identify current level of performance 2. Identify effectiveness of communication systems 3. Identify areas to be improved 4. Identify strategies to stabilize or improve processes 5. Evaluate whether outcomes were achieved 6. Compare results with standards, and best practices, using statistical techniques. <p>... J. Performance improvement activities will be monitored and documented."</p> <p>8. The agency's policy titled "Agency Annual Evaluation," # B-240, effective date 07/01/07, stated "A. The components of the evaluation include but are not limited to:</p> <ol style="list-style-type: none"> 1. Organizational structure and systems review ... 3. Clinical record review 4. Program review or appropriateness, adequacy effectiveness, efficiency of client care." <p>9. The ISDH pre-survey report dated 6/13/16 listed previous employee AA as the Alternate Nursing Supervisor.</p> <p>10. During interview on 6/28/16 at 11:05 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor left the agency in April, the position is currently vacant but employee D (Assistant Clinical Manager) will be taking that role once she takes her</p>			

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G 0134 Bldg. 00	<p>Registered Nurse licensure exam this summer.</p> <p>11. During interview on 6/28/16 at 11:05 AM, employee A stated he did not think the ISDH had been notified of the change yet, and that the acting Alternate Nursing Supervisor would be employee C (Alternate Administrator).</p> <p>12. During interview on 6/29/16 at 11:05 AM, the Administrator stated employee C is the acting Alternate Nursing Supervisor.</p> <p>13. During interview on 6/29/16 at 11:07 AM, employee C stated they just realized yesterday that the ISDH was not notified that the previous Alternate Nursing Supervisor left in April, so the agency sent a notification.</p> <p>14. On 6/28/16 at 2:01 PM, ISDH an email was received back from ISDH Program Secretary and stated "I don't have any record of staff changes from this facility."</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the</p>						

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	<p>supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 2 of 7 employee files reviewed. (C and N)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee files were reviewed on 7/7/16. Employee file C (Alternate Administrator), date of hire 2/13/13, failed to contain a job description. <ul style="list-style-type: none"> A. During interview on 7/7/16 at 11:55 AM, the Administrator stated she could not find the job description. 2. Employee file N (home health aide), date of hire 1/8/10, first patient contact date 7/1/10, failed to contain a copy of the Home Health Aide competency test. 3. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list. 4. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... 	G 0134	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present. All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files</p>	07/11/2016

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G 0158 Bldg. 00	<p>Orientation sheets Signed Job Description."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on document review and interview, the agency failed to ensure skilled nurse (SN) visits were conducted as ordered on the plan of care for 6 of 10 clinical records reviewed (# 1, 2, 5, 6, 9 and 10); and failed to ensure any as needed (PRN) visits ordered contained a reason for the PRN visits for 1 of 10 clinical records reviewed (# 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The plan of care dated 5/21-7/19/16 contained orders for SN 8-12 hours a day, 5-7 days a week for 60 days. The agency failed to ensure SN hours provided were not more than 12 hours per day.</p> <p>A. The Nursing flow sheet dated 5/22-5/23/16 evidenced the shift began at 10 PM on 5/22 and ended on 5/23 at 7 AM; a total of 7 hours on 5/23/16. The Nursing flow sheet dated 5/23/16</p>	G 0158	<p>StaffingCoordinator and Clinical Care Assistant Manager have been instructed on theirresponsibility to adhere to staffed hours as ordered by the physician. At weekly staff meetings, during client casereviews, the client schedules are reviewed for agency compliance in adhering tophysician orders. Over usages or under utilization in hours will be discussedand the primary physician will be alerted. Any changes per physician order willbe followed and schedules will be adjusted accordingly. Missed visit forms will accompanyunderutilization of hours and include documentation of reason. The Director isresponsible for monitoring this weekly process. HPHC quarterly audits will beconducted and include documentation review to ensure the shift frequency is consistentwith physician orders. If not, a missed visit document will be present andinclude the reasons why the shift was missed and the physician was notified.The Director is</p>	07/22/2016

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	<p>evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 5/23-5/24/16 evidenced the shift began at 10 PM on 5/23; a total of 2 hours. The combined hours for 5/23/16 totaled 17 hours.</p> <p>B. The Nursing flow sheet dated 5/23-5/24/16 evidenced the shift began at 10 PM on 5/23 and ended on 5/24 at 7 AM; a total of 7 hours on 5/24/16. The Nursing flow sheet dated 5/24/16 evidenced the next shift was from 9:30 AM-5 PM; a total of 7.5 hours. The Nursing flow sheet dated 5/24-5/25/16 evidenced the shift began at 10 PM on 5/24; a total of 2 hours. The combined hours for 5/24/16 totaled 16.5 hours.</p> <p>C. The Nursing flow sheet dated 5/24-5/25/16 evidenced the shift began at 10 PM on 5/24 and ended on 5/25 at 7 AM; a total of 7 hours on 5/25/16. The Nursing flow sheet dated 5/25/16 evidenced the next shift was from 8:20 AM-4:30 PM; a total of just over 8 hours. The Nursing Flow sheet dated 5/25/16 evidenced the next shift began at 10:40 PM on 5/25; a total of 1.25 hours. The combined hours for 5/25/16 totaled 16.25 hours.</p> <p>D. The Nursing Flow sheet dated 5/25/16 evidenced the next shift began at</p>		<p>responsible for the completion and reporting of quarterly audits. Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process and following frequency orders) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases.</p> <p>For PRN visits, ordered by the physician, clarification will be obtained for the need of those PRN visits. The Director will be responsible to ensure that all future visit cases will be audited for compliance.</p> <p>Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. This will also be reviewed in the HPHC's audit process with the admission of new visit cases and with the quarterly audits.</p>		

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	<p>10:40 PM on 5/25 and ended on 5/26 at 7 AM; a total of 7 hours on 5/26/16. This is under the ordered hours by 1 hour for 5/26/16.</p> <p>E. The Nursing flow sheet dated 5/30-31/16 evidenced the shift began at 10 PM on 5/30 and ended on 5/31 at 7 AM; a total of 7 hours on 5/31/16. The Nursing flow sheet dated 5/31/16 evidenced the next shift was from 9 AM -5 PM; a total of 8 hours. The combined hours for 5/31/16 totaled 15 hours.</p> <p>F. The Nursing flow sheet dated 6/2/16 evidenced the shift began at 10 PM on 6/2 and ended on 6/3 at 8 AM; a total of 8 hours on 6/3/16. The Nursing flow sheet dated 6/3/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/3-6/4/16 evidenced the net shift began at 10 PM on 6/3/16; a total of 2 hours. The combined hours for 6/3/16 totaled 18 hours.</p> <p>G. The Nursing flow sheet dated 6/5/16 evidenced the shift began at 10 PM on 6/5 and ended on 6/6 at 8 AM; a total of 8 hours on 6/6/16. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The combined hours for 6/6/16 totaled 16 hours.</p>			

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	<p>H. The Nursing flow sheet dated 6/9/16 evidenced the shift began at 10 PM on 6/9 and ended on 6/10/ at 8:15 AM; a total of 8.25 hours on 6/10. The Nursing flow sheet dated 6/10/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The combined hours for 6/10/16 totaled 16.25 hours.</p> <p>I. The Nursing flow sheet dated 6/12-6/13/16 evidenced the shift began at 10 PM on 6/12 and ended on 6/13 at 7 AM; a total of 7 hours on 6/13. The Nursing flow sheet dated 6/13/16 evidenced the next shift was from 7 AM-4:30 PM; a total of 8.5 hours. The Nursing flow sheet dated 6/13-6/14/16 evidenced the next shift began at 10 PM on 6/13; a total of 2 hours. The combined hours for 6/13/16 totaled 17.5 hours.</p> <p>J. The Nursing flow sheet dated 6/13-6/14/16 evidenced the next shift began at 10 PM on 6/13 and ended on 6/14 at 7 AM; a total of 7 hours on 6/14. The Nursing flow sheet dated 6/14/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/14/16 evidenced the next shift began at 10 PM on 6/14; a total of 2 hours. The combined hours for 6/14/16 totaled 17</p>			

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	<p>hours.</p> <p>K. The Nursing flow sheet dated 6/16/16 evidenced the shift began at 10 PM on 6/16 and ended on 6/17 at 8 AM; a total of 8 hours on 6/17. The Nursing flow sheet dated 6/17 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/17-6/18 evidenced the next shift began at 10 PM on 6/17; a total of 2 hours. The combined hours for 6/17/16 totaled 18 hours.</p> <p>L. The Nursing flow sheet dated 6/19-6/20/16 evidenced the shift began at 10 PM on 6/19 and ended on 6/20 at 7 AM; a total of 7 hours on 6/20. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/20-6/21 evidenced the next shift began at 10 PM on 6/20; a total of 2 hours. The combined hours for 6/20/16 totaled 17 hours.</p> <p>M. The Nursing flow sheet dated 6/20-6/21/16 evidenced the shift began at 10 PM on 6/20 and ended on 6/21 at 7 AM; a total of 7 hours on 6/21. The Nursing flow sheet dated 6/21/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The</p>			

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	<p>Nursing flow sheet dated 6/21-6/22 evidenced the next shift began at 10 PM on 6/21; a total of 2 hours. The combined hours for 6/21/16 totaled 17 hours.</p> <p>N. During interview on 6/29/16 at 1:35 PM, employee A (Nursing Supervisor) stated the agency was using more than the 83 hours per week, they did not obtain orders for them; and he calculated 5/21-today and the hours provided are more than 83 hours a week in most weeks, that is the agency's fault, and the parent would request more hours so staff would just stay and provide the hours but they were not properly documented as waiver (respite) or pre-authorized hours.</p> <p>2. Clinical record # 2 was reviewed on 7/6/16. Start of care date 7/25/14. The plan of care dated 5/10-7/8/16 contained orders for SN 7-16 hours a day, 4-6 days a week for 60 days, Waiver hours to be used at parents' discretion. The agency failed to ensure SN hours provided were not more than 16 hours a day.</p> <p>A. The Nursing flow sheet dated 5/10/16 evidenced the shift began at 10 PM and concluded on 5/11/16 at 7 AM; a total of 7 hours on 5/11/16. The Nursing flow sheet dated 5/11/16 evidenced the</p>			

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	<p>next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/11/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/11/16 totaled 18.5 hours.</p> <p>B. The Nursing flow sheet dated 5/11/16 evidenced the shift began at 10 PM and concluded on 5/12/16 at 7 AM; a total of 7 hours on 5/12/16. The Nursing flow sheet dated 5/12/16 evidenced the next shift was from 7 AM-5:05 PM; a total of 10 hours. The Nursing flow sheet dated 5/12/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/12/16 totaled 19 hours.</p> <p>C. The Nursing flow sheet dated 5/12/16 evidenced the shift began at 10 PM and concluded on 5/13/16 at 7 AM; a total of 7 hours on 5/13/16. The Nursing flow sheet dated 5/13/16 evidenced the next shift was from 7 AM-5:15 PM; a total of 10.25 hours. The combined hours for 5/13/16 totaled 17.5 hours.</p> <p>D. The Nursing flow sheet dated 5/15/16 evidenced the shift began at 10 PM and concluded on 5/16/16 at 7 AM; a total of 7 hours on 5/16/16. The Nursing flow sheet dated 5/16/16 evidenced the</p>			

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	<p>next shift was from 7 AM through 5 PM; a total of 10 hours. The Nursing flow sheet dated 5/16/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/16/16 totaled 19 hours.</p> <p>E. The Nursing flow sheet dated 5/16/16 evidenced the shift began at 10 PM and concluded on 5/17/16 at 7 AM; a total of 7 hours on 5/17/16. The Nursing flow sheet dated 5/16/16 evidenced the next shift was from 7 AM through 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 5/17/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/17/16 totaled 18.75 hours.</p> <p>F. The Nursing flow sheet dated 5/17/16 evidenced the shift began at 10 PM and concluded on 5/18/16 at 7 AM; a total of 7 hours on 5/18/16. The Nursing flow sheet dated 5/18/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/18/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/18/16 totaled 18.5 hours.</p> <p>G. The Nursing flow sheet dated</p>			

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	<p>5/18/16 evidenced the shift began at 10 PM and concluded on 5/19/16 at 7 AM; a total of 7 hours on 5/19/16. The Nursing flow sheet dated 5/19/16 evidenced the next shift was from 7 AM through 4:40 PM; a total of approximately 9.75 hours. The Nursing flow sheet dated 5/19/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/19/16 totaled 18.5 hours.</p> <p>H. The Nursing flow sheet dated 5/19/16 evidenced the shift began at 10 PM and concluded on 5/20/16 at 7 AM; a total of 7 hours on 5/20/16. The Nursing flow sheet dated 5/20/16 evidenced the next shift was from 7 AM through 5:20 PM; a total of approximately 10.25 hours. The combined hours for 5/20/16 totaled 17.25 hours.</p> <p>I. The Nursing flow sheet dated 5/23/16 evidenced the shift began at 10 PM and concluded on 5/24/16 at 7 AM; a total of 7 hours on 5/24/16. The Nursing flow sheet dated 5/24/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/24/16 evidenced the next shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The combined hours for 5/24/16 totaled 19.5 hours.</p>			

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	<p>J. The Nursing flow sheet dated 5/24/16 evidenced the shift began at 9 PM and concluded on 5/25/16 at 7 AM; a total of 7 hours on 5/25/16. The Nursing flow sheet dated 5/25/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/25/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/25/16 totaled 18.5 hours.</p> <p>K. The Nursing flow sheet dated 5/30/16 evidenced the shift began at 10 PM and concluded on 5/31/16 at 7 AM; a total of 7 hours on 5/31/16, and the shift was marked as PA hours on the first page, and then as Respite hours on the last page. The Nursing flow sheet dated 5/31/16 evidenced the next shift was from 7 AM through 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 5/31/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/31/16 totaled 18.75 hours.</p> <p>L. The Nursing flow sheet dated 5/31/16 evidenced the shift began at 10 PM and concluded on 6/1/16 at 7:15 AM; a total of 7.25 hours on 6/1/16. The Nursing flow sheet dated 6/1/16</p>			

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	<p>evidenced the next shift was from 7:15 AM through 5:15 PM; a total of 10 hours. The Nursing flow sheet dated 6/1/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/1/16 totaled 19.25 hours.</p> <p>M. The Nursing flow sheet dated 6/1/16 evidenced the shift began at 10 PM and concluded on 6/2/16 at 7 AM; a total of 7 hours on 6/2/16. The Nursing flow sheet dated 6/2/16 evidenced the next shift was from 7 AM through 4:40 PM; a total of approximately 9.75 hours. The Nursing flow sheet dated 6/2/16 evidenced the next shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The combined hours for 6/2/16 totaled approximately 19.75 hours.</p> <p>N. The Nursing flow sheet dated 6/2/16 evidenced the shift began at 9 PM and concluded on 6/3/16 at 7 AM; a total of 7 hours on 6/3/16. The Nursing flow sheet dated 6/3/16 evidenced the next shift was from 7 AM - 5:20 PM; a total of approximately 10.25 hours. The combined hours for 6/3/16 totaled approximately 17.25 hours.</p> <p>O. The Nursing flow sheet dated 6/5/16 evidenced the shift began at 10 PM and concluded on 6/6/16 at 7:35 AM;</p>			

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	<p>a total of approximately 7.5 hours on 6/6/16. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 7:30 AM - 5:10 PM; a total of approximately 9.5 hours, and was marked as PA hours on the first page, and respite hours on the third page. The Nursing flow sheet dated 6/6/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM; and was marked as PA hours on the first page, and respite hours on the third page. The combined hours for 6/6/16 totaled approximately 19 hours.</p> <p>P. The Nursing flow sheet dated 6/6/16 evidenced the shift began at 10 PM and concluded on 6/7/16 at 7 AM; a total of 7 hours on 6/7/16. The Nursing flow sheet dated 6/7/16 evidenced the next shift was from 7 AM - 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 6/7/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/7/16 totaled 18.5 hours.</p> <p>Q. The Nursing flow sheet dated 6/7/16 evidenced the shift began at 10 PM and concluded on 6/8/16 at 7 AM; a total of 7 hours on 6/8/16. The Nursing flow sheet dated 6/8/16 evidenced the next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet</p>			

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	<p>dated 6/8/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/8/16 totaled 19 hours.</p> <p>R. The Nursing flow sheet dated 6/8/16 evidenced the shift began at 10 PM and concluded on 6/9/16 at 7 AM; a total of 7 hours on 6/9/16. The Nursing flow sheet dated 6/9/16 evidenced the next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet dated 6/9/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/9/16 totaled 19 hours.</p> <p>S. The Nursing flow sheet dated 6/9/16 evidenced the shift began at 10 PM and concluded on 6/10/16 at 7 AM; a total of 7 hours on 6/10/16. The Nursing flow sheet dated 6/10/16 evidenced the next shift was from 7 AM - 5:30 PM; a total of 10.5 hours. The combined hours for 6/10/16 totaled 17.5 hours.</p> <p>T. The Nursing flow sheet dated 6/13/16 evidenced the shift began at 10 PM and concluded on 6/14/16 at 7 AM; a total of 7 hours on 6/14/16. The Nursing flow sheet dated 6/14/16 evidenced the next shift was from 7 AM - 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 6/14/16 evidenced the next</p>			

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	<p>shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The combined hours for 6/14/16 totaled 19.5 hours.</p> <p>U. The Nursing flow sheet dated 6/14/16 evidenced the shift began at 10 PM and concluded on 6/15/16 at 7 AM; a total of 7 hours on 6/15/16. The Nursing flow sheet dated 6/15/16 evidenced the next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet dated 6/15/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/15/16 totaled 19 hours.</p> <p>V. The Nursing flow sheet dated 6/19/16 evidenced the shift began at 10 PM and concluded on 6/20/16 at 7 AM; a total of 7 hours on 6/20/16, and was marked as PA hours on the first page, and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 7 AM - 4:40 PM; a total of approximately 9.75 hours, and was marked as PA hours on the first page and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/20/16 totaled 18.75 hours.</p> <p>W. The Nursing flow sheet dated</p>			

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	<p>6/20/16 evidenced the shift began at 10 PM and concluded on 6/21/16 at 7 AM; a total of 7 hours on 6/21/16. The Nursing flow sheet dated 6/21/16 evidenced the next shift was from 7 AM - 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 6/21/16 evidenced the next shift began at 8 PM; a total of 4 hours from 8 PM-12 AM. The combined hours for 6/21/16 totaled 20.75 hours.</p> <p>X. The Nursing flow sheet dated 6/21/16 evidenced the shift began at 8 PM and concluded on 6/22/16 at 7 AM; a total of 7 hours on 6/22/16. The Nursing flow sheet dated 6/22/16 evidenced the next shift was from 7 AM - 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 6/22/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/22/16 totaled 18.5 hours.</p> <p>Y. The Nursing flow sheet dated 6/23/16 evidenced the shift began at 10 PM and concluded on 6/24/16 at 7 AM; a total of 7 hours on 6/24/16. The Nursing flow sheet dated 6/24/16 evidenced the next shift was from 7 AM - 5:15 PM; a total of 10.25 hours. The combined hours for 6/24/16 totaled 17.25 hours.</p> <p>3. The clinical record for patient # 5 was reviewed on 7/6/16. Start of care date</p>			

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	<p>11/6/10. The plan of care dated 5/24-7/22/16 contained orders for SN 6-10 hours a day, 3-5 days a week, Respite hours to be scheduled per parents' request. The record evidenced the agency provided SN services 6 days a week for 3 weeks, and failed to evidence a physician order was obtained for these extra visits.</p> <p>A. The record evidenced SN services were provided on 6/6, 6/7, 6/8, 6/9, 6/10, and 6/11/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/6-6/12/16.</p> <p>B. The record evidenced SN services were provided on 6/13, 6/14, 6/15, 6/16, 6/17, and 6/18/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/13-6/19/16.</p> <p>C. The record evidenced SN services were provided on 6/20, 6/21, 6/22, 6/23, 6/24, and 6/25/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/20-6/26/16.</p> <p>4. Clinical record #6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN 8-14 hours a day, 4-6 days a week for a total of 65 hours per week; respite hours as needed. The record</p>			

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	<p>evidenced the agency failed to provide 8-14 hours a day on 4/23, 5/7, 5/10, 5/14, 5/28, 6/4, and 6/18/16, and failed to evidence the physician was notified of the shorter hours provided.</p> <p>A. The Nursing Flow Sheet dated 4/23/16 evidenced the shift was from 7 AM - 2:15 PM, a total of 7.25 hours.</p> <p>B. The Nursing Flow Sheet dated 5/7/16 evidenced the shift was from 7 AM - 12:45 PM, a total of 5.75 hours.</p> <p>C. The Nursing Flow Sheet dated 5/10/16 evidenced the shift was from 9:45 AM - 5 PM, a total of 7.25 hours.</p> <p>D. The Nursing Flow Sheet dated 5/14/16 evidenced the shift was from 7 AM - 1:15 PM, a total of 6.25 hours.</p> <p>E. The Nursing Flow Sheet dated 5/28/16 evidenced the shift was from 6 AM - 11:30 AM, a total of 5.5 hours.</p> <p>F. The Nursing Flow Sheet dated 6/4/16 evidenced the shift was from 6:30 AM - 12:30 PM, a total of 6 hours.</p> <p>G. The Nursing Flow Sheet dated 6/18/16 evidenced the shift was from 6:30 AM - 12:30 PM, a total of 6 hours.</p>			

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	<p>H. During interview on 7/6/16 at 2:20 PM, employee A (Nursing Supervisor) stated usually the parents come home and send our workers home early.</p> <p>5. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week fro 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to evidence a reason for the PRN visits, failed to evidence 3 visits were conducted from 2/17-2/21/16, and failed to evidence the physician was notified of the missed visits.</p> <p>A. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>B. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN) performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital signs of temperature, pulse and respirations.</p>			

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	<p>C. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>E. The Skilled Nursing Visit note dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated they did notice the vitals were not completed when the record was reviewed; and the PRN visits were if anything was needed past the ordered visits.</p> <p>G. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor (employee AA) handled this case, and it was a difficult family to get a hold of and the agency was not able to get into the home until 2/19, but this was not documented.</p> <p>H. During interview on 7/7/16 at</p>			

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	<p>10:00 AM employee D (Assistant Clinical Manager) stated the patient was in the hospital, but this is not documented.</p> <p>I. The Lutheran Hospital Daily Progress Notes dated 2/15/2016 stated "Plan: D/C home. ... HHC [home health care] visits ordered."</p> <p>6. The clinical record for patient # 10 was reviewed on 7/6/16. Start of care date 9/8/08. The plan of care dated 5/22-7/20/16 contained orders for SN 5-8 hours a day, 4-6 days a week for 60 days, respite up to 480 hours a year. The record failed to evidence the agency provided 5-8 hours for 3 days from 5/22-6/22/16.</p> <p>A. The Nursing Flow Sheet dated 5/27/16 evidenced the shift was from 8:30 AM-12:30 PM for PA hours, for a total of 4 hours.</p> <p>B. The Nursing Flow Sheet dated 6/8/16 evidenced the shift was from 11:00 AM-2:30 PM for PA hours, then 2:30-6:30 PM for respite; for a total of 3.5 PA hours.</p> <p>C. The Nursing Flow Sheet dated 6/22/16 evidenced the shift was from 12:35 PM-4:45 PM for PA hours, for a</p>			

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	<p>total of approximately 4-4.25 hours.</p> <p>D. During interview on 7/6/16 at 9:45 Am, employee A stated the agency combines the PA and Respite hours, but he saw how it's ordered, and had nothing to say.</p> <p>7. The agency's policy titled "Plan of Care," # C-580, revised 07/01/07 stated "B. The Plan of Care shall be completed in full to include: ... 5. Type, frequency, and duration of all visits/services ... 15. Medical supplies and equipment required ... 23. Other appropriate items i.e. equipment and medical supplies. 24. All of the above items must always be addressed on the Plan of Care. ... C. If a physician refers a client under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan. The skilled assessment visit order will be documented on a Doctor's Order Form and mailed to the physician for signature. ... E. The Plan of Care/485 will be developed following the initial assessment ... I. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. ... K. The PRN orders will be accompanied by a description of the client's needs that could warrant a</p>			

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G 0159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, document review and interview, the agency failed to ensure all durable medical equipment (DME), disciplines, and hours for services were on the plan of care for 2 of 10 clinical records reviewed (# 1, and 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/6/15. The plan of care dated 5/21-7/19/16 contained orders for skilled nursing (SN) 8-12 hours a day, 5-7 days a week for 60 days; and listed DME and Supplies of Trach</p>	G 0159	Director/Assistant Clinical Care Manager have reviewed the requirements on the 485. The Director sent an in service to all staff members on 7/22/16 as to the requirements on the 485 and the nurse's responsibility of reporting any changes to the nursing supervisor. During home supervisory visits all sections of the 485 will be reviewed in the home with the present nurse and/or caregiver for accuracy. If new orders are indicated they will be obtained.	07/22/2016

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	<p>supplies, suction machine and supplies, nebulizer with supplies, Oxygen concentrator with tubing and humidifier bottle, sterile water, enteral formula with feed bags and tubing, syringes, gloves, and stethoscope. The DME section failed to include the stander, and the plan of care failed to include respite hours were available and Pre-Authorized hours were 83 hours a week.</p> <p>A. During home visit on 6/29/16 at 9:00 AM with patient #1, DME in the home included a stander.</p> <p>B. During record review on 6/29/16, respite hours were documented as having been provided on 5/21, 5/22, 5/27, 5/31, 6/8, 6/15, and 6/19/16.</p> <p>2. During interview on 6/29/16 at 1:10 PM, employee A (Nursing Supervisor) stated he was not sure when patient #1 received a stander, but the respite hours should be on the plan of care, and if staff are providing respite hours they should be marking them as "waiver" hours.</p> <p>3. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. The plan of care dated 2/17-4/15/16 contained orders for Home visits 3 times a week fro 2 weeks, two times a week for</p>			

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G 0168 Bldg. 00	<p>2 weeks, and then PRN. The record failed to list which discipline was ordered.</p> <p>A. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated all the visits are skilled nurse visit since we did not have any Home Health Aide cases at that time.</p> <p>4. The agency's policy titled "Plan of Care," # C-580, revised 07/01/07 stated "B. The Plan of Care shall be completed in full to include: ... 5. Type, frequency, and duration of all visits/services ... 15. Medical supplies and equipment required ... 23. Other appropriate items i.e. equipment and medical supplies. 24. All of the above items must always be addressed on the Plan of Care. ... K. The PRN orders will be accompanied by a description of the client's needs that could warrant a visit.</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on document review and interview, the agency failed to ensure the nurses provided services as ordered on the plan of care for 2 of 10 clinical</p>	G 0168	Credible Allegation of Compliance Action: The Director in conjunction with the Assistant Clinical Care Manager has reviewed and updated all active clients 485's to ensure that they	07/22/2016

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	<p>records reviewed (See G 170); failed to ensure the Registered Nurses updated the plans of care and necessary revisions for 2 of 10 clinical records reviewed (See G 173); and failed to ensure the Registered Nurses documented per policy for 1 of 10 records reviewed (See G 176).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nursing.</p>		<p>are current and accurate. An in service to all staff members was sent 7/22/16 covering the requirements on the 485 and the nurse's responsibility of reporting any changes to the nursing supervisor. Nursing staff was also in serviced on nursing documentation as it relates to orders on the 485. The Director was responsible and completed 100% of the client charts audited by 7/22/16. To follow up and ensure accuracy all sections of the 485 will be reviewed with the current nurse and/or caregiver during each home supervisory visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly. 100% of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures are present in the client documentation. Nursing staff and Clinical Care Mangers (CCM) have been reeducated on consistency and accuracy of orders to the 485 and all accompanying paperwork. When the CCM creates or revises a treatmentsheet or any accompanying paperwork the nurse in the home will review for consistency and accuracy. The Director will ensure continued compliance through 10% or 10</p>	

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			charts audited quarterly. Director has been reeducated on the requirements per policy for documenting discharge of a client, specifically reason for discharge. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. An admission and weekly chart view will occur with all future nursing visits by the Director. An audit will be performed with all discharge visit cases and reviewed quarterly. Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases. The Director in conjunction with the Assistant Clinical Care Manager has	

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G 0170 Bldg. 00	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on document review and interview, the agency failed to ensure the nurses provided services as ordered on the plan of care for 2 of 10 clinical records reviewed. (# 6, and 9)</p> <p>Findings include</p> <p>1. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN (skilled nurse) 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate Trach cuff for longer periods of time</p>	G 0170	<p>reviewed and updated all active clients 485's or any accompanying paperwork to ensure that they are current and accurate. The Director was responsible and completed 100% of the client charts audited by 7/22/16. To follow up and ensure accuracy, all sections of the 485 and any accompanying paperwork will be reviewed with the current nurse and/or caregiver during each home supervisory visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly</p> <p>Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders on the 485. Director/Assistant Clinical Care Manager have reviewed that the requirements are contained on the 485. During home supervisory visits all sections of the 485 will be reviewed in the home with the present nurse and/or caregiver for accuracy. If new orders are indicated they will be obtained Currently HPHC has no active</p>	07/22/2016

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	<p>during the day; Assessment/Vitals: Temperature, Pulse, Respiration every 4 hours and PRN, blood pressure PRN, Review of symptoms: Assess respiratory, cardiovascular, integumentary, gastrointestinal, genitourinary, and musculoskeletal status every 4 hours and PRN, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the nurse failed to measure vital signs and perform assessments as ordered by the physician.</p> <p>A. The Nursing Flow Sheet dated 4/26/16 from 6:30 AM-5:15 PM failed to evidence temperature and pulse were recorded at 3:00 PM.</p> <p>B. The Nursing Flow Sheet dated 4/29/16 from 6 AM-4:15 PM failed to evidence temperature, pulse, respirations, oxygen saturation, and Assessment of systems were recorded at 2:00 PM.</p> <p>C. The Nursing Flow Sheet dated 5/11/16 from 6:30 AM-5:30 PM failed to evidence temperature, pulse, and oxygen saturation were recorded at 3:00 PM.</p> <p>D. The Nursing Flow Sheet dated 5/27/16 from 6:30 AM-5:00 PM failed to evidence oxygen saturation was recorded at 3:00 PM.</p>		<p>skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. This will also be reviewed with the admission of new visit cases and with the quarterly audits</p>	

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	<p>E. The Nursing Flow Sheet dated 6/14/6 from 6:30 AM-5:30 PM failed to evidence oxygen saturation was recorded at 3:00 PM.</p> <p>2. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week fro 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to evidence a reason for the PRN visits, failed to evidence 3 visits were conducted from 2/17-2/21/16, and failed to evidence the physician was notified of the missed visits.</p> <p>A. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>B. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN) performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital</p>			

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	<p>signs of temperature, pulse and respirations.</p> <p>C. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>E. The Skilled Nursing Visit note dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated they did notice the vitals were not completed when the record was reviewed; and the PRN visits were if anything was needed past the ordered visits.</p> <p>G. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor (employee AA) handled this case, and it was a difficult family to get a hold of and the agency was not able to get into the home until 2/19, but this was not documented.</p>			

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G 0173 Bldg. 00	<p>H. During interview on 7/7/16 at 10:00 AM employee D (Assistant Clinical Manager) stated the patient was in the hospital, but this is not documented.</p> <p>I. The Lutheran Hospital Daily Progress Notes dated 2/15/2016 stated "Plan: D/C home. ... HHC [home health care] visits ordered."</p> <p>3. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on document review, and</p>	G 0173	The Director in conjunction with	07/22/2016	

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	<p>interview, the agency failed to ensure the Registered Nurses updated the plans of care and necessary revisions for 2 of 10 clinical records reviewed. (# 1, and 6)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The plan of care dated 5/21-7/19/16 contained a diagnosis of respiratory failure, and had listed Trach supplies under durable medical equipment. In the section titled "Trach" the Trach size listed was 4.0 with an emergency Trach size 3.5 ordered.</p> <p>A. The record evidenced a physician's order dated 4/29/16 at 11 AM and stated "Change trach to a 3.5 PEDS [pediatric] Shiley uncuffed.-when available ... Have 3.0 PEDS uncuffed Shiley for back-up emergency." The current plan of care failed to include the trach size change.</p> <p>B. The un-signed Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 stated Tracheostomy size 4.0. This document failed to include the change of the trach size per physician order from 4/29/16.</p> <p>C. When asked for a copy of this document, employee C(Alternate</p>		<p>the Assistant Clinical Care Manager has reviewed and updated all active clients 485's to ensure that they are current and accurate. The Director was responsible and completed 100% of the client charts audited by 7/22/16. To follow up and ensure accuracy all sections of the 485 will be reviewed with the current nurse and/or caregiver during each home supervisory visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly. Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders on the 485. 100% of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures are present in the client documentation</p>		

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	<p>Administrator) returned the document signed as 5/20/16, and failed to provide a copy of the document while it was un-signed.</p> <p>D. During interview on 6/29/16 at 12:00 PM, employee C stated she had the nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>E. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>2. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN (skilled nurse) 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate Trach cuff for longer periods of time during the day, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the nurse failed to ensure the accuracy of the plan of care orders to the treatment sheets.</p> <p>A. The Patient Care and Treatment Schedules dated 4/18-4/24, 5/2-5/8,</p>			

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G 0176 Bldg. 00	<p>5/9-5/15, 5/16-5/22, 5/23-5/29, 5/30-6/5, 6/6-6/12, and 6/13-6/19/16 stated "Inflate trach longer periods of time during day as tolerates ... Oximeter check-Sats [saturation] ... BID [twice daily]."</p> <p>3. The agency's policy titled "Plan of Care," # C-580, revised 07/01/07 stated "I. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</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. Based on document review and interview, the agency failed to ensure the Registered Nurses (RNs) documented per policy for 1 of 10 records reviewed (# 1). Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 was not signed by the nurse. When asked for a copy of this document, employee C(Alternate Administrator)</p>	G 0176	100% of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures were present in client documentation. Staffing Coordinator and Clinical Care Assistant Manager have been instructed on their responsibility to adhere to staffed hours as ordered by the physician. At weekly staff meetings, during client case reviews, the client schedules are reviewed for agency compliance in adhering to physician orders. Over usages or	07/22/2016

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	<p>returned the document signed as 5/20/16, and failed to provide a copy of the document while it was un-signed.</p> <p>A. During interview on 6/29/16 at 12:00 PM, employee C stated she had the nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>B. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>C. During interview on 6/30/16 at 11:17 AM, employee C stated typically documents are to be signed when they are completed.</p> <p>2. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and</p>		<p>underutilization in hours will be discussed and the primary physician will be alerted. Any changes per physician order will be followed and schedules will be adjusted accordingly. Missed visit forms will accompany underutilization of hours and include documentation of reason. The Director is responsible for monitoring this weekly process. HPHC quarterly audits will be conducted and include documentation review to ensure the shift frequency is consistent with physician orders. If not, a missed visit document will be present and include the reasons why the shift was missed and the physician was notified. The Director is responsible for the completion and reporting of quarterly audits</p>	

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G 0221 Bldg. 00	<p>reported to the physician within current certification period."</p> <p>484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must maintain documentation which demonstrates that the requirements of this standard are met. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 1 of 3 Home Health Aide (HHA) files reviewed. (N)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee files were reviewed on 7/7/16. Employee file N (HHA), date of hire 1/8/10, first patient contact date 7/1/10, and last patient contact date 9/16/15, failed to contain a copy of the Home Health Aide competency test. 3. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list. 4. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, 	G 0221	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present. All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files</p>	07/11/2016

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G 0235 Bldg. 00	<p>stated "Home Health Aide Test ... Orientation sheets Signed Job Description."</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on document review and interview, the agency failed to ensure staff followed policies for clinical documentation fro 2 of 10 records reviewed; failed to ensure Pre-Authorized hours and Respite hours were clearly marked on the discipline flow sheets for 1 of 10 records reviewed; failed to ensure the accuracy of the plan of care orders to the treatment sheets for 1 of 10 records reviewed; failed to ensure the discharge summary included the reason for discharge and the most recent discipline orders, and failed to evidence documentation for the admission assessment not being completed within 48 hours of referral for 1 of 10 records reviewed (See G 236); and failed to ensure the discharge summary included the reason for discharge for 1 of 3 discharge records reviewed (See G 303).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of</p>	G 0235	<p>Credible Allegation of Compliance Action: 100% of client charts was audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures are present in the client documentation Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. Nursing staff was also instructed that when performing PA hours to not check off the boxes (Reason for Respite) on the flowsheet as these are separate and different services. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders on the 485. The Director reviewed 100% of client 485's to ensure accuracy related to client needs, duration of the order (POC for 60 days) and clearly marked and separated required hours for PA and Waiver. Physician orders were obtained as needed Nursing staff and</p>	07/22/2016

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G 0236 Bldg. 00	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		Clinical Care Mangers (CCM) have been reeducated on consistency and accuracy of orders to the 485 and all accompanying paperwork. When the CCM creates or revises a treatmentsheet or any accompanying paperwork the nurse in the home will review for consistency and accuracy. The Director will ensure continued compliance through 10% or 10charts audited quarterly. Director has been reeducated on the requirements per policy for discharging a client,specifically reason for discharge. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases	

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	<p>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 document review and interview, the agency failed to ensure staff followed policies for clinical documentation fro 2 of 10 records reviewed (# 1, and 9); failed to ensure Pre-Authorized hours and Respite hours were clearly marked on the discipline flow sheets for 1 of 10 records reviewed (# 2); failed to ensure the accuracy of the plan of care orders to the treatment sheets for 1 of 10 records reviewed (# 6); failed to ensure the discharge summary included the reason for discharge and the most recent discipline orders, and failed to evidence documentation for the admission assessment not being completed within 48 hours of referral for 1 of 10 records reviewed (# 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 was not signed by the nurse. When asked for a copy of this document, employee C(Alternate Administrator) returned the document signed, and failed</p>	G 0236	<p>100%of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature is not a common occurrence. 100% of signatures are present in the client documentation. Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. Nursing staff was also instructed that when performing PA hours to not check off the boxes (Reason for Respite)on the flowsheet as these are separate and different services. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders onthe 485. The Director reviewed 100% of client 485's to ensure accuracy related to client needs, duration of the order (POC for 60 days) and clearly marked and separated required hours for PA and Waiver. Physician orders were obtained as needed. Nursing staff and Clinical Care Mangers (CCM) have been reeducated on consistency and accuracy of orders to the 485 and all</p>	07/22/2016

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	<p>to provide a copy of the document while it was un-signed.</p> <p>A. During interview on 6/29/16 at 12:00 PM, employee C stated she had the nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>B. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>C. During interview on 6/30/16 at 11:17 AM, employee C stated typically documents are to be signed when they are completed.</p> <p>2. Clinical record # 2 was reviewed on 7/6/16. Start of care date 7/25/14. The plan of care dated 5/10-7/8/16 contained orders for SN 7-16 hours a day, 4-6 days a week for 60 days, Waiver hours to be used at parents' discretion. The agency failed to ensure SN hours were clearly marked as Pre-Authorized (PA) hours or Respite/Waiver hours.</p> <p>A. The Nursing flow sheet dated 5/30/16 evidenced the shift began at 10 PM and concluded on 5/31/16 at 7 AM. The shift was marked as PA hours on the</p>		<p>accompanying paperwork. When the CCM creates or revises a treatment sheet or any accompanying paperwork the nurse in the home will review for consistency and accuracy. The Director will ensure continued compliance through 10% or 10 charts audited quarterly. The Director in conjunction with the Assistant Clinical Care Manager has reviewed and updated all active clients 485's and any accompanying paperwork to ensure that they are current and accurate. The Director was responsible and completed 100% of the client charts audited by 7/22/16. To follow up and ensure accuracy, all sections of the 485 and any accompanying paperwork will be reviewed with the current nurse and/or caregiver during each home supervisory visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly. Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process and following frequency orders) will be reviewed and the Director will oversee this process. An admission and weekly</p>				

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	<p>first page, and then as Respite hours on the last page.</p> <p>B. The Nursing flow sheet dated 6/5/16 evidenced the shift began at 10 PM and concluded on 6/6/16 at 7 AM. The shift was marked as PA hours on the first page, and then as Respite hours on the last page.</p> <p>C. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 7:30 AM - 5:10 PM, and was marked as PA hours on the first page, and respite hours on the third page. The Nursing flow sheet dated 6/6/16 evidenced the next shift began at 10 PM and was marked as PA hours on the first page, and respite hours on the third page.</p> <p>D. The Nursing flow sheet dated 6/19/16 evidenced the shift began at 10 PM and concluded on 6/20/16 at 7 AM, and was marked as PA hours on the first page, and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 7 AM - 4:40 PM, and was marked as PA hours on the first page and Respite hours on the third page.</p> <p>3. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date</p>		<p>documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases Director has been reeducated on the requirements per policy for documenting the discharge of a client, specifically reason for discharge. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. This will also be reviewed in the HPHC's audit process with the discharge and admission of new visit cases and with the quarterly audits.</p>		

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	<p>5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate trach cuff for longer periods of time during the day, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the agency failed to ensure the accuracy of the plan of care orders to the treatment sheets.</p> <p>A. The Patient Care and Treatment Schedules dated 4/18-4/24, 5/2-5/8, 5/9-5/15, 5/16-5/22, 5/23-5/29, 5/30-6/5, 6/6-6/12, and 6/13-6/19/16 stated "Inflate trach longer periods of time during day as tolerates ... Oximeter check-Sats [saturation] ... BID [twice daily]."</p> <p>4. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week for 2 weeks, two times a week for 2 weeks, and then PRN. The discharge summary failed to evidence the reason for discharge and failed to ensure the listed services included the most recent orders; and failed to evidence documentation for the</p>			

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	<p>admission assessment not being completed within 48 hours of referral.</p> <p>A. The record evidenced a physician order was received on 2/22/16 to decrease the SN visits to one time a week.</p> <p>B. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>C. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN) performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>E. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. The Skilled Nursing Visit note</p>			

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G 0244 Bldg. 00	<p>dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>5. The agency's policy titled "Discharge Summary," # C-820, effective date 07/01/07, stated "B. The Discharge Summary ... shall include, but not be limited, to: ... 7. Reason for discharge."</p> <p>6. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. Based on document review and interview, the agency failed to ensure the</p>	G 0244	Hobart OASIS data entry person has begun to communicate (call/email)	07/22/2016			

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	<p>Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects, and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p> <p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via</p>		<p>withthe Fort Wayne office when OASIS error messages occur. The Fort Wayneoffice will keep a log of this communication for QA. The error messages will be investigatedand corrected as needed. Director is responsible for pulling OASISsubmission and final validation reports. The Director is also responsible for pulling Potential Avoidable Event, errorand additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. TheDirector will be responsible for monitoring trends and initiating action plansas necessary. This has begun in the month of July.</p>		

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	<p>secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p> <p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p> <p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p> <p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p>			

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G 0303 Bldg. 00	<p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors but they do not document this communication; and the Administrator stated the Fort Wayne office had not seen error reports.</p> <p>2. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the agency reviewed OASIS submission and final validation reports.</p> <p>3. The agency's policy titled "Agency Annual Evaluation," # B-240, effective date 07/01/07, stated "A. The components of the evaluation include but are not limited to: 1. Organizational structure and systems review ... 3. Clinical record review 4. Program review or appropriateness, adequacy effectiveness, efficiency of client care."</p> <p>484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the</p>						

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	<p>patient's medical and health status at discharge.</p> <p>Based on document review and interview, the agency failed to ensure the discharge summary included the reason for discharge for 1 of 3 discharge records reviewed (#9).</p> <p>Findings include</p> <p>1. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week fro 2 weeks, two times a week for 2 weeks, and then PRN. The discharge summary failed to evidence the reason for discharge, and listed the services provided as 3 times a week for 2 weeks/2 times a week for 2 weeks.</p> <p>A. The record evidenced a physician order was received on 2/22/16 to decrease the SN visits to one time a week.</p> <p>B. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor) stated the discharge summary should list a reason for discharge.</p>	G 0303	<p>Director has been reeducated on the requirements per policy for discharging a client, specifically reason for discharge.</p> <p>Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. This will also be reviewed in the HPHC's audit process with the discharge and admission of new visit cases and with the quarterly audits</p>	07/22/2016

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G 0324 Bldg. 00	<p>2. The agency's policy titled "Discharge Summary," # C-820, effective date 07/01/07, stated "B. The Discharge Summary ... shall include, but not be limited, to: ... 7. Reason for discharge."</p> <p>484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section. Based on document review and interview, the agency failed to ensure the Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects,</p>	G 0324	<p>Hobart OASIS data entry person has begun to communicate (call/email) with the Fort Wayne office when OASIS error messages occur. The Fort Wayne office will keep a log of this communication for QA. The error messages will be investigated and corrected as needed. Director is responsible for pulling OASIS submission and final validation. The Director is also responsible for pulling Potential Avoidable Event, error and additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. The Director will be responsible for monitoring trends and initiating action plans as necessary. This has begun in the month of July.</p>	07/22/2016

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	<p>and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p> <p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p> <p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p> <p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the</p>			

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	<p>OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p> <p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p> <p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors but they do not document this communication; and the Administrator stated the Fort Wayne office had not seen error reports, and the agency does not have a contract or agreement for this, but the employee at Hobart has signed a confidentiality agreement.</p> <p>2. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the agency reviewed OASIS submission and final validation reports.</p>			

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G 0332 Bldg. 00	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>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 document review and interview, the agency failed to ensure admission assessments were completed with 48 hours of referral for 1 of 10 clinical records reviewed. (# 9)</p> <p>Findings include</p> <p>1. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 contained orders for Home visits 3 times a week for 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to evidence the admission assessment was not conducted until 2/19/16 and failed to evidence a reason for the delay.</p> <p>A. The Lutheran Hospital Daily Progress Notes dated 2/15/2016 stated "Plan: D/C home. ... HHC [home health care] visits ordered."</p> <p>B. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor)</p>	G 0332	Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases. For PRN visits, ordered by the physician, clarification will be obtained for the need of those PRN visits. The Director will be responsible to ensure that all future visit cases will be audited for compliance. Director has been reeducated on the requirements per policy for discharging a client, specifically reason for discharge. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care	07/22/2016

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N 0000 Bldg. 00	<p>stated the previous Alternate Nursing Supervisor (employee AA) handled this case, and it was a difficult family to get a hold of and the agency was not able to get into the home until 2/19, but this was not documented.</p> <p>C. During interview on 7/7/16 at 10:00 AM employee D (Assistant Clinical Manager) stated the patient was in the hospital, but this is not documented.</p> <p>2. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."</p>		<p>regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. This will also be reviewed in the HPHC's audit process with the discharge and admission of new visit cases and with the quarterly audits</p>	

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N 0408 Bldg. 00	<p>This was a state home health licensure survey.</p> <p>Survey Dates: June 28, 29, 30, and July 6, and 7, 2016</p> <p>Facility Number: 004219</p> <p>Medicaid Number: 200889890B</p> <p>Census Service Type: Skilled: 36 Home Health Aide Only: 1 Personal Care Only: 0 Total: 37</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>410 IAC 17-10-1(d) Licensure Rule 10 Sec. 1(d) Disclosure of ownership</p>	N 0000	<p>HomePointe HealthCare (HPHC) acknowledges that a survey was completed by representative from the Indiana State Department of Health on June 28, 29, 30 and July 6, 7 of 2016 HPHC recognizes that we are precluded from providing our own home health aide training and competency evaluation program for a period of 2 years beginning July 7, 2016 through July 7, 2018. We currently do not have home health aide clients because we are primarily a pediatric extended care agency Prior to admitting a home health aide case, HPHC will contract with an outside Registered Nurse to preform the competency training and evaluation of individuals hired.</p>	

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	<p>and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following:</p> <p>(1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency.</p> <p>(2) Each person who is:</p> <p>(A) an officer;</p> <p>(B) a director;</p> <p>(C) a managing agent; or</p> <p>(D) a managing employee;</p> <p>of the home health agency and evidence supporting the qualifications required by this article.</p> <p>(3) The corporation, association, or other company that is responsible for the management of the home health agency.</p> <p>(4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency.</p> <p>Based on document review and interview, the agency failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The ISDH pre-survey report dated 6/13/16 listed previous employee AA as the Alternate Nursing Supervisor.</p>	N 0408	This deficiency was corrected on 6/30/16, the Agency Staff Notification Form was completed and fax with additional required documents to the ISDH Awaiting confirmation The Administrator will ensure that the state is notified of any changes upon resignation/termination of the Administrator or Director of Nursing and their alternates	07/11/2016

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	<p>2. During interview on 6/28/16 at 11:05 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor left the agency in April, the position is currently vacant but employee D (Assistant Clinical Manager) will be taking that role once she takes her Registered Nurse licensure exam this summer.</p> <p>3. During interview on 6/28/16 at 11:05 AM, employee A stated he did not think the ISDH had been notified of the change yet, and that the acting Alternate Nursing Supervisor would be employee C (Alternate Administrator).</p> <p>4. During interview on 6/29/16 at 11:05 AM, the Administrator stated employee C is the acting Alternate Nursing Supervisor.</p> <p>5. During interview on 6/29/16 at 11:07 AM, employee C stated they just realized yesterday that the ISDH was not notified that the previous Alternate Nursing Supervisor left in April, so the agency sent a notification.</p> <p>6. On 6/28/16 at 2:01 PM, ISDH an email was received back from ISDH Program Secretary and stated "I don't have any record of staff changes from this facility."</p>			

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N 0444 Bldg. 00	<p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 2 of 7 employee files reviewed (C and N); failed to ensure the Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency; and failed to ensure the Quality Assurance Report included OASIS submission and errors review, and failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency.</p>	N 0444	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present and notify ISDH regarding appropriate administrative changes. All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no</p>	07/22/2016

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	<p>Findings include</p> <ol style="list-style-type: none"> Employee files were reviewed on 7/7/16. Employee file C (Alternate Administrator), date of hire 2/13/13, failed to contain a job description. <ul style="list-style-type: none"> A. During interview on 7/7/16 at 11:55 AM, the Administrator stated she could not find the job description. Employee file N (home health aide), date of hire 1/8/10, first patient contact date 7/1/10, failed to contain a copy of the Home Health Aide competency test. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... Orientation sheets Signed Job Description." The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete 		<p>longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files. Hobart OASIS data entry person has begun to communicate (call/email) with the Fort Wayne office when OASIS error messages occur. The Fort Wayne office will keep a log of this communication for QA. The error messages will be investigated and corrected as needed. Director is responsible for pulling OASIS submission and final validation reports. The Director is also responsible for pulling Potential Avoidable Event, error and additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. The Director will be responsible for monitoring trends and initiating action plans as necessary. This has begun in the month of July.</p>		

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	<p>Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects, and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p> <p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p> <p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p>			

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	<p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p> <p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p> <p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors but they do not document this communication; and the Administrator stated the Fort Wayne office had not seen error reports.</p> <p>6. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the</p>			

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	<p>agency reviewed OASIS submission and final validation reports.</p> <p>7. The agency's policy titled "Performance Improvement," # B-260, effective date 07/01/07, stated "Procedure A. ... Program will reflect participation by all services and levels of staff; and will subscribe to compliance with internal and external standards including the Medicare Conditions of Participation. ... E. Data will be assessed to: 1. Identify current level of performance 2. Identify effectiveness of communication systems 3. Identify areas to be improved 4. Identify strategies to stabilize or improve processes 5. Evaluate whether outcomes were achieved 6. Compare results with standards, and best practices, using statistical techniques. ... J. Performance improvement activities will be monitored and documented."</p> <p>8. The agency's policy titled "Agency Annual Evaluation," # B-240, effective date 07/01/07, stated "A. The components of the evaluation include but are not limited to: 1. Organizational structure and systems review ... 3. Clinical record review 4. Program review or appropriateness, adequacy effectiveness, efficiency of client care."</p> <p>9. The ISDH pre-survey report dated</p>			

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	<p>6/13/16 listed previous employee AA as the Alternate Nursing Supervisor.</p> <p>10. During interview on 6/28/16 at 11:05 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor left the agency in April, the position is currently vacant but employee D (Assistant Clinical Manager) will be taking that role once she takes her Registered Nurse licensure exam this summer.</p> <p>11. During interview on 6/28/16 at 11:05 AM, employee A stated he did not think the ISDH had been notified of the change yet, and that the acting Alternate Nursing Supervisor would be employee C (Alternate Administrator).</p> <p>12. During interview on 6/29/16 at 11:05 AM, the Administrator stated employee C is the acting Alternate Nursing Supervisor.</p> <p>13. During interview on 6/29/16 at 11:07 AM, employee C stated they just realized yesterday that the ISDH was not notified that the previous Alternate Nursing Supervisor left in April, so the agency sent a notification.</p> <p>14. On 6/28/16 at 2:01 PM, ISDH an email was received back from ISDH</p>			

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N 0446 Bldg. 00	<p>Program Secretary and stated "I don't have any record of staff changes from this facility."</p> <p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 2 of 7 employee files reviewed. (C and N)</p> <p>Findings include</p> <p>1. Employee files were reviewed on 7/7/16. Employee file C (Alternate Administrator), date of hire 2/13/13, failed to contain a job description.</p> <p>A. During interview on 7/7/16 at 11:55 AM, the Administrator stated she could not find the job description.</p>	N 0446	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present. All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency. HR/Director will ensure that all</p>	07/11/2016

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N 0449 Bldg. 00	<p>2. Employee file N (home health aide), date of hire 1/8/10, first patient contact date 7/1/10, failed to contain a copy of the Home Health Aide competency test.</p> <p>3. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list.</p> <p>4. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... Orientation sheets Signed Job Description."</p> <p>410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 2 of 7 employee files reviewed (C and N); failed to ensure the Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency; and</p>	N 0449	<p>required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files</p> <p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present and notify ISDH regarding appropriate administrative changes. All personnel files will be audited</p>	07/22/2016

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	<p>failed to ensure the Quality Assurance Report included OASIS submission and errors review, and failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> Employee files were reviewed on 7/7/16. Employee file C (Alternate Administrator), date of hire 2/13/13, failed to contain a job description. <ul style="list-style-type: none"> A. During interview on 7/7/16 at 11:55 AM, the Administrator stated she could not find the job description. Employee file N (home health aide), date of hire 1/8/10, first patient contact date 7/1/10, failed to contain a copy of the Home Health Aide competency test. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... Orientation sheets Signed Job 		<p>a minimum of annually.</p> <p>The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files. Hobart OASIS data entry person has begun to communicate (call/email) with the Fort Wayne office when OASIS error messages occur. The Fort Wayne office will keep a log of this communication for QA. The error messages will be investigated and corrected as needed. Director is responsible for pulling OASIS submission and final validation reports. The Director is also responsible for pulling Potential Avoidable Event, error and additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. The Director will be responsible for monitoring trends and initiating action plans as necessary. This has begun in the month of July.</p>	

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	<p>Description."</p> <p>5. The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects, and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p> <p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p>				

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	<p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p> <p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p> <p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p> <p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors</p>			

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	<p>but they do not document this communication; and the Administrator stated the Fort Wayne office had not seen error reports.</p> <p>6. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the agency reviewed OASIS submission and final validation reports.</p> <p>7. The agency's policy titled "Performance Improvement," # B-260, effective date 07/01/07, stated "Procedure A. ... Program will reflect participation by all services and levels of staff; and will subscribe to compliance with internal and external standards including the Medicare Conditions of Participation. ... E. Data will be assessed to: 1. Identify current level of performance 2. Identify effectiveness of communication systems 3. Identify areas to be improved 4. Identify strategies to stabilize or improve processes 5. Evaluate whether outcomes were achieved 6. Compare results with standards, and best practices, using statistical techniques. ... J. Performance improvement activities will be monitored and documented."</p> <p>8. The agency's policy titled "Agency Annual Evaluation," # B-240, effective date 07/01/07, stated "A. The</p>			

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	<p>components of the evaluation include but are not limited to: 1. Organizational structure and systems review ... 3. Clinical record review 4. Program review or appropriateness, adequacy effectiveness, efficiency of client care."</p> <p>9. The ISDH pre-survey report dated 6/13/16 listed previous employee AA as the Alternate Nursing Supervisor.</p> <p>10. During interview on 6/28/16 at 11:05 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor left the agency in April, the position is currently vacant but employee D (Assistant Clinical Manager) will be taking that role once she takes her Registered Nurse licensure exam this summer.</p> <p>11. During interview on 6/28/16 at 11:05 AM, employee A stated he did not think the ISDH had been notified of the change yet, and that the acting Alternate Nursing Supervisor would be employee C (Alternate Administrator).</p> <p>12. During interview on 6/29/16 at 11:05 AM, the Administrator stated employee C is the acting Alternate Nursing Supervisor.</p> <p>13. During interview on 6/29/16 at 11:07</p>			

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N 0456 Bldg. 00	<p>AM, employee C stated they just realized yesterday that the ISDH was not notified that the previous Alternate Nursing Supervisor left in April, so the agency sent a notification.</p> <p>14. On 6/28/16 at 2:01 PM, ISDH an email was received back from ISDH Program Secretary and stated "I don't have any record of staff changes from this facility."</p> <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: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on document review and interview, the agency failed to ensure the Hobart office shared Outcome Assessment Information Set (OASIS) final validation reports with the Fort Wayne office for 1 of 1 agency.</p> <p>Findings include</p>	N 0456	Administratorhad Employee C (Alternate Administrator) sign appropriate job description thatwas missing from personnel file. Administrator/Director will audit all newhire, personnel files to ensure that all required documentation is presentand notify ISDH regarding appropriate administrative changes.	07/22/2016

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	<p>1. The Potentially Avoidable Event Report: Patient Listing dated 3/2015-2/2016 received from the Indiana State Department of Health (ISDH) database, and printed 06/24/2016, evidenced the agency had 2 Complete Data Cases listed in the subject areas of: Emergent Care for Injury Caused by Fall, Emergent Care for Wound Infections, Deteriorating Wound Status, Emergent Care for Improper Medication Administration, Medication Side Effects, and Emergent Care for Hypo/Hyperglycemia. This document failed to list any patient names for selection and record review.</p> <p>A. During interview on 6/28/16 at 11:28 AM, employee A (Nursing Supervisor) stated the agency does not submit its own OASIS data, this is submitted through the Hobart office which is not a branch or satellite office, but it is separately licensed. Employee A stated the information collected by the nurses is reviewed by him and then emailed to Hobart as attachments via secure email.</p> <p>B. During interview on 6/28/16 at 11:30 AM, employee A stated the agency does not pull up final validation reports.</p>		<p>All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee N is no longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files. Hobart OASIS data entry person has begun to communicate (call/email) with the Fort Wayne office when OASIS error messages occur. The Fort Wayne office will keep a log of this communication for QA. The error messages will be investigated and corrected as needed. Director is responsible for pulling OASIS submission and final validation reports. The Director is also responsible for pulling Potential Avoidable Event, error and additional CASPER reports as indicated. Reports will be reviewed quarterly during Performance Improvement/QA meetings by the Director. The Director will be responsible for monitoring trends and initiating action plans as necessary. This has begun in the month of July.</p>		

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	<p>C. During interview on 6/29/16 at 11:05 AM, the Administrator stated Homepointe is a "doing business as" under Anthony Wayne Holdings, LLC, but the national provider number is the same for all Homepointe offices.</p> <p>D. During interview on 6/30/16 at 11:10 AM, employee A stated the Fort Wayne Homepointe office has more pediatric an adult clients, so due to a limited number of OASIS needing to be submitted, this office does not have the OASIS computer. Employee A stated he believes that the Alternate Administrator receives the feedback reports, as she is also the Director at the Hobart office.</p> <p>E. During interview on 6/30/16 at 11:12 AM, employee C (Alternate Administrator) stated we have not gotten feedback- Hobart can run the reports, and the employee who does the submissions does get reports and if there are any errors, she will call the Fort Wayne office. Employee C stated there are rarely any errors for the Fort Wayne office.</p> <p>F. During interview on 7/6/16 at 10:30 AM, the Administrator stated the Hobart employee who submits OASIS does call Fort Wayne if there are errors but they do not document this</p>			

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N 0470 Bldg. 00	<p>communication; and the Administrator stated the Fort Wayne office had not seen error reports.</p> <p>2. Review of the agency's Quality Assurance Report dated July 2014 through June 2015 failed to evidence the agency reviewed OASIS submission and final validation reports.</p> <p>3. The agency's policy titled "Agency Annual Evaluation," # B-240, effective date 07/01/07, stated "A. The components of the evaluation include but are not limited to: 1. Organizational structure and systems review ... 3. Clinical record review 4. Program review or appropriateness, adequacy effectiveness, efficiency of client care."</p> <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. Based on observation, document review and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 5 home</p>	N 0470	The Director has in serviced all staff members on 7/22/16. The in service included an informational packet from the WHO titled Hand Hygiene Why, How and When.	07/22/2016

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	<p>visits (patient # 4).</p> <p>Findings include</p> <p>1. During home visit on 6/30/16 at 11:00 AM with patient #4, employee I (Registered Nurse) was observed providing G button care, dressing patient, shaving patient and brushing patient's teeth. Employee I failed to wash hands after removing gloves, and failed to wash hands for longer than 3-7 seconds.</p> <p>A. After employee I shaved patient's face, she removed her gloves and washed hands for 3 seconds. Employee I failed to wash hands longer than 3 seconds.</p> <p>B. After brushing patient's teeth, employee I removed her gloves, then donned new gloves. Employee I failed to wash her hands or use hand sanitizer in between glove changes.</p> <p>C. Employee I applied cream to patient's skin on face, removed her gloves, then donned new gloves. Employee I failed to wash her hands or use hand sanitizer in between glove changes.</p> <p>D. After brushing patient's teeth, employee I rinsed the tooth brush, then washed her hands for 7 seconds.</p>		<p>This includes instructional material on hand and glove hygiene procedures. HPHC's Hand and Glove Hygiene Competency Evaluation has been updated to include hand hygiene duration and glove hygiene procedures The Clinical Care Manager/Director will monitor staff's adherence/ compliance through home supervisory visits on each client a minimum of every 60days during supervisory visits. During orientation and annually, staff will demonstrate competency for hand and glove hygiene</p>	

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	<p>Employee I failed to wash hands longer than 7 seconds.</p> <p>2. During interview on 7/6/16 at 9:45 AM, employee A (Nursing Supervisor) stated staff should be singing the ABC's while washing hands, or at least washing hands for 30 seconds, and employees should be washing hands in between glove changes.</p> <p>3. The agency's policy titled "Handwashing," no number, revised 08/06/14 stated "Procedure: ... G. Hands should be rubbed vigorously during washing for at least 30 seconds with special attention paid to the backs and fingertips."</p> <p>4. The agency's procedure titled "How to Handwash?" stated "Wash hands when visibly soiled! Otherwise, use handrub ... Duration of the entire procedure: 40-60 seconds."</p> <p>5. The agency's policy titled "Infection Prevention," # B-403, effective date 07/01/07 stated "Standard Precautions-Tier One ... B. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganism between other clients or</p>			

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N 0522 Bldg. 00	<p>the environment."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on document review and interview, the agency failed to ensure skilled nurse (SN) visits were conducted as ordered on the plan of care for 6 of 10 clinical records reviewed (# 1, 2, 5, 6, 9 and 10); and failed to ensure any as needed (PRN) visits ordered contained a reason for the PRN visits for 1 of 10 clinical records reviewed (# 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The plan of care dated 5/21-7/19/16 contained orders for SN 8-12 hours a day, 5-7 days a week for 60 days. The agency failed to ensure SN hours provided were not more than 12 hours per day.</p> <p>A. The Nursing flow sheet dated 5/22-5/23/16 evidenced the shift began at 10 PM on 5/22 and ended on 5/23 at 7</p>	N 0522	StaffingCoordinator and Clinical Care Assistant Manager have been instructed on theirresponsibility to adhere to staffed hours as ordered by the physician. At weekly staff meetings, during client casereviews, the client schedules are reviewed for agency compliance in adhering tophysician orders. Over usages or under utilization in hours will be discussedand the primary physician will be alerted. Any changes per physician order willbe followed and schedules will be adjusted accordingly. Missed visit forms will accompanyunderutilization of hours and include documentation of reason. The Director isresponsible for monitoring this weekly process. HPHC quarterly audits will beconducted and include documentation review to ensure the shift frequency is consistentwith physician orders. If not, a missed visit document will be present andinclude the	07/22/2016

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	<p>AM; a total of 7 hours on 5/23/16. The Nursing flow sheet dated 5/23/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 5/23-5/24/16 evidenced the shift began at 10 PM on 5/23; a total of 2 hours. The combined hours for 5/23/16 totaled 17 hours.</p> <p>B. The Nursing flow sheet dated 5/23-5/24/16 evidenced the shift began at 10 PM on 5/23 and ended on 5/24 at 7 AM; a total of 7 hours on 5/24/16. The Nursing flow sheet dated 5/24/16 evidenced the next shift was from 9:30 AM-5 PM; a total of 7.5 hours. The Nursing flow sheet dated 5/24-5/25/16 evidenced the shift began at 10 PM on 5/24; a total of 2 hours. The combined hours for 5/24/16 totaled 16.5 hours.</p> <p>C. The Nursing flow sheet dated 5/24-5/25/16 evidenced the shift began at 10 PM on 5/24 and ended on 5/25 at 7 AM; a total of 7 hours on 5/25/16. The Nursing flow sheet dated 5/25/16 evidenced the next shift was from 8:20 AM-4:30 PM; a total of just over 8 hours. The Nursing Flow sheet dated 5/25/16 evidenced the next shift began at 10:40 PM on 5/25; a total of 1.25 hours. The combined hours for 5/25/16 totaled 16.25 hours.</p>		<p>reasons why the shift was missed and the physician was notified. The Director is responsible for the completion and reporting of quarterly audits. Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process and following frequency orders) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases. For PRN visits, ordered by the physician, clarification will be obtained for the need of those PRN visits. The Director will be responsible to ensure that all future visit cases will be audited for compliance. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. This will also be reviewed in the HPHC's audit process with the admission of new visit case and with the quarterly audits.</p>		

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	<p>D. The Nursing Flow sheet dated 5/25/16 evidenced the next shift began at 10:40 PM on 5/25 and ended on 5/26 at 7 AM; a total of 7 hours on 5/26/16. This is under the ordered hours by 1 hour for 5/26/16.</p> <p>E. The Nursing flow sheet dated 5/30-31/16 evidenced the shift began at 10 PM on 5/30 and ended on 5/31 at 7 AM; a total of 7 hours on 5/31/16. The Nursing flow sheet dated 5/31/16 evidenced the next shift was from 9 AM -5 PM; a total of 8 hours. The combined hours for 5/31/16 totaled 15 hours.</p> <p>F. The Nursing flow sheet dated 6/2/16 evidenced the shift began at 10 PM on 6/2 and ended on 6/3 at 8 AM; a total of 8 hours on 6/3/16. The Nursing flow sheet dated 6/3/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/3-6/4/16 evidenced the net shift began at 10 PM on 6/3/16; a total of 2 hours. The combined hours for 6/3/16 totaled 18 hours.</p> <p>G. The Nursing flow sheet dated 6/5/16 evidenced the shift began at 10 PM on 6/5 and ended on 6/6 at 8 AM; a total of 8 hours on 6/6/16. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 9 AM-5 PM; a total</p>			

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	<p>of 8 hours. The combined hours for 6/6/16 totaled 16 hours.</p> <p>H. The Nursing flow sheet dated 6/9/16 evidenced the shift began at 10 PM on 6/9 and ended on 6/10/ at 8:15 AM; a total of 8.25 hours on 6/10. The Nursing flow sheet dated 6/10/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The combined hours for 6/10/16 totaled 16.25 hours.</p> <p>I. The Nursing flow sheet dated 6/12-6/13/16 evidenced the shift began at 10 PM on 6/12 and ended on 6/13 at 7 AM; a total of 7 hours on 6/13. The Nursing flow sheet dated 6/13/16 evidenced the next shift was from 7 AM-4:30 PM; a total of 8.5 hours. The Nursing flow sheet dated 6/13-6/14/16 evidenced the next shift began at 10 PM on 6/13; a total of 2 hours. The combined hours for 6/13/16 totaled 17.5 hours.</p> <p>J. The Nursing flow sheet dated 6/13-6/14/16 evidenced the next shift began at 10 PM on 6/13 and ended on 6/14 at 7 AM; a total of 7 hours on 6/14. The Nursing flow sheet dated 6/14/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/14/16 evidenced the next shift began at 10 PM</p>			

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	<p>on 6/14; a total of 2 hours. The combined hours for 6/14/16 totaled 17 hours.</p> <p>K. The Nursing flow sheet dated 6/16/16 evidenced the shift began at 10 PM on 6/16 and ended on 6/17 at 8 AM; a total of 8 hours on 6/17. The Nursing flow sheet dated 6/17 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/17-6/18 evidenced the next shift began at 10 PM on 6/17; a total of 2 hours. The combined hours for 6/17/16 totaled 18 hours.</p> <p>L. The Nursing flow sheet dated 6/19-6/20/16 evidenced the shift began at 10 PM on 6/19 and ended on 6/20 at 7 AM; a total of 7 hours on 6/20. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/20-6/21 evidenced the next shift began at 10 PM on 6/20; a total of 2 hours. The combined hours for 6/20/16 totaled 17 hours.</p> <p>M. The Nursing flow sheet dated 6/20-6/21/16 evidenced the shift began at 10 PM on 6/20 and ended on 6/21 at 7 AM; a total of 7 hours on 6/21. The Nursing flow sheet dated 6/21/16</p>			

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	<p>evidenced the next shift was from 9 AM-5 PM; a total of 8 hours. The Nursing flow sheet dated 6/21-6/22 evidenced the next shift began at 10 PM on 6/21; a total of 2 hours. The combined hours for 6/21/16 totaled 17 hours.</p> <p>N. During interview on 6/29/16 at 1:35 PM, employee A (Nursing Supervisor) stated the agency was using more than the 83 hours per week, they did not obtain orders for them; and he calculated 5/21-today and the hours provided are more than 83 hours a week in most weeks, that is the agency's fault, and the parent would request more hours so staff would just stay and provide the hours but they were not properly documented as waiver (respite) or pre-authorized hours.</p> <p>2. Clinical record # 2 was reviewed on 7/6/16. Start of care date 7/25/14. The plan of care dated 5/10-7/8/16 contained orders for SN 7-16 hours a day, 4-6 days a week for 60 days, Waiver hours to be used at parents' discretion. The agency failed to ensure SN hours provided were not more than 16 hours a day.</p> <p>A. The Nursing flow sheet dated 5/10/16 evidenced the shift began at 10 PM and concluded on 5/11/16 at 7 AM; a</p>			

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	<p>total of 7 hours on 5/11/16. The Nursing flow sheet dated 5/11/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/11/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/11/16 totaled 18.5 hours.</p> <p>B. The Nursing flow sheet dated 5/11/16 evidenced the shift began at 10 PM and concluded on 5/12/16 at 7 AM; a total of 7 hours on 5/12/16. The Nursing flow sheet dated 5/12/16 evidenced the next shift was from 7 AM-5:05 PM; a total of 10 hours. The Nursing flow sheet dated 5/12/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/12/16 totaled 19 hours.</p> <p>C. The Nursing flow sheet dated 5/12/16 evidenced the shift began at 10 PM and concluded on 5/13/16 at 7 AM; a total of 7 hours on 5/13/16. The Nursing flow sheet dated 5/13/16 evidenced the next shift was from 7 AM-5:15 PM; a total of 10.25 hours. The combined hours for 5/13/16 totaled 17.5 hours.</p> <p>D. The Nursing flow sheet dated 5/15/16 evidenced the shift began at 10 PM and concluded on 5/16/16 at 7 AM; a</p>			

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	<p>total of 7 hours on 5/16/16. The Nursing flow sheet dated 5/16/16 evidenced the next shift was from 7 AM through 5 PM; a total of 10 hours. The Nursing flow sheet dated 5/16/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/16/16 totaled 19 hours.</p> <p>E. The Nursing flow sheet dated 5/16/16 evidenced the shift began at 10 PM and concluded on 5/17/16 at 7 AM; a total of 7 hours on 5/17/16. The Nursing flow sheet dated 5/16/16 evidenced the next shift was from 7 AM through 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 5/17/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/17/16 totaled 18.75 hours.</p> <p>F. The Nursing flow sheet dated 5/17/16 evidenced the shift began at 10 PM and concluded on 5/18/16 at 7 AM; a total of 7 hours on 5/18/16. The Nursing flow sheet dated 5/18/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/18/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/18/16 totaled 18.5 hours.</p>			

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	<p>G. The Nursing flow sheet dated 5/18/16 evidenced the shift began at 10 PM and concluded on 5/19/16 at 7 AM; a total of 7 hours on 5/19/16. The Nursing flow sheet dated 5/19/16 evidenced the next shift was from 7 AM through 4:40 PM; a total of approximately 9.75 hours. The Nursing flow sheet dated 5/19/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/19/16 totaled 18.5 hours.</p> <p>H. The Nursing flow sheet dated 5/19/16 evidenced the shift began at 10 PM and concluded on 5/20/16 at 7 AM; a total of 7 hours on 5/20/16. The Nursing flow sheet dated 5/20/16 evidenced the next shift was from 7 AM through 5:20 PM; a total of approximately 10.25 hours. The combined hours for 5/20/16 totaled 17.25 hours.</p> <p>I. The Nursing flow sheet dated 5/23/16 evidenced the shift began at 10 PM and concluded on 5/24/16 at 7 AM; a total of 7 hours on 5/24/16. The Nursing flow sheet dated 5/24/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/24/16 evidenced the next shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The</p>			
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	<p>combined hours for 5/24/16 totaled 19.5 hours.</p> <p>J. The Nursing flow sheet dated 5/24/16 evidenced the shift began at 9 PM and concluded on 5/25/16 at 7 AM; a total of 7 hours on 5/25/16. The Nursing flow sheet dated 5/25/16 evidenced the next shift was from 7 AM through 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 5/25/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/25/16 totaled 18.5 hours.</p> <p>K. The Nursing flow sheet dated 5/30/16 evidenced the shift began at 10 PM and concluded on 5/31/16 at 7 AM; a total of 7 hours on 5/31/16, and the shift was marked as PA hours on the first page, and then as Respite hours on the last page. The Nursing flow sheet dated 5/31/16 evidenced the next shift was from 7 AM through 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 5/31/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 5/31/16 totaled 18.75 hours.</p> <p>L. The Nursing flow sheet dated 5/31/16 evidenced the shift began at 10 PM and concluded on 6/1/16 at 7:15 AM;</p>			

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	<p>a total of 7.25 hours on 6/1/16. The Nursing flow sheet dated 6/1/16 evidenced the next shift was from 7:15 AM through 5:15 PM; a total of 10 hours. The Nursing flow sheet dated 6/1/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/1/16 totaled 19.25 hours.</p> <p>M. The Nursing flow sheet dated 6/1/16 evidenced the shift began at 10 PM and concluded on 6/2/16 at 7 AM; a total of 7 hours on 6/2/16. The Nursing flow sheet dated 6/2/16 evidenced the next shift was from 7 AM through 4:40 PM; a total of approximately 9.75 hours. The Nursing flow sheet dated 6/2/16 evidenced the next shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The combined hours for 6/2/16 totaled approximately 19.75 hours.</p> <p>N. The Nursing flow sheet dated 6/2/16 evidenced the shift began at 9 PM and concluded on 6/3/16 at 7 AM; a total of 7 hours on 6/3/16. The Nursing flow sheet dated 6/3/16 evidenced the next shift was from 7 AM - 5:20 PM; a total of approximately 10.25 hours. The combined hours for 6/3/16 totaled approximately 17.25 hours.</p> <p>O. The Nursing flow sheet dated</p>				

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	<p>6/5/16 evidenced the shift began at 10 PM and concluded on 6/6/16 at 7:35 AM; a total of approximately 7.5 hours on 6/6/16. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 7:30 AM - 5:10 PM; a total of approximately 9.5 hours, and was marked as PA hours on the first page, and respite hours on the third page. The Nursing flow sheet dated 6/6/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM; and was marked as PA hours on the first page, and respite hours on the third page. The combined hours for 6/6/16 totaled approximately 19 hours.</p> <p>P. The Nursing flow sheet dated 6/6/16 evidenced the shift began at 10 PM and concluded on 6/7/16 at 7 AM; a total of 7 hours on 6/7/16. The Nursing flow sheet dated 6/7/16 evidenced the next shift was from 7 AM - 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 6/7/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/7/16 totaled 18.5 hours.</p> <p>Q. The Nursing flow sheet dated 6/7/16 evidenced the shift began at 10 PM and concluded on 6/8/16 at 7 AM; a total of 7 hours on 6/8/16. The Nursing flow sheet dated 6/8/16 evidenced the</p>			

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	<p>next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet dated 6/8/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/8/16 totaled 19 hours.</p> <p>R. The Nursing flow sheet dated 6/8/16 evidenced the shift began at 10 PM and concluded on 6/9/16 at 7 AM; a total of 7 hours on 6/9/16. The Nursing flow sheet dated 6/9/16 evidenced the next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet dated 6/9/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/9/16 totaled 19 hours.</p> <p>S. The Nursing flow sheet dated 6/9/16 evidenced the shift began at 10 PM and concluded on 6/10/16 at 7 AM; a total of 7 hours on 6/10/16. The Nursing flow sheet dated 6/10/16 evidenced the next shift was from 7 AM - 5:30 PM; a total of 10.5 hours. The combined hours for 6/10/16 totaled 17.5 hours.</p> <p>T. The Nursing flow sheet dated 6/13/16 evidenced the shift began at 10 PM and concluded on 6/14/16 at 7 AM; a total of 7 hours on 6/14/16. The Nursing flow sheet dated 6/14/16 evidenced the next shift was from 7 AM - 4:30 PM; a</p>			

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	<p>total of 9.5 hours. The Nursing flow sheet dated 6/14/16 evidenced the next shift began at 9 PM; a total of 3 hours from 9 PM-12 AM. The combined hours for 6/14/16 totaled 19.5 hours.</p> <p>U. The Nursing flow sheet dated 6/14/16 evidenced the shift began at 10 PM and concluded on 6/15/16 at 7 AM; a total of 7 hours on 6/15/16. The Nursing flow sheet dated 6/15/16 evidenced the next shift was from 7 AM - 5 PM; a total of 10 hours. The Nursing flow sheet dated 6/15/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/15/16 totaled 19 hours.</p> <p>V. The Nursing flow sheet dated 6/19/16 evidenced the shift began at 10 PM and concluded on 6/20/16 at 7 AM; a total of 7 hours on 6/20/16, and was marked as PA hours on the first page, and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 7 AM - 4:40 PM; a total of approximately 9.75 hours, and was marked as PA hours on the first page and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/20/16 totaled 18.75 hours.</p>			

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	<p>W. The Nursing flow sheet dated 6/20/16 evidenced the shift began at 10 PM and concluded on 6/21/16 at 7 AM; a total of 7 hours on 6/21/16. The Nursing flow sheet dated 6/21/16 evidenced the next shift was from 7 AM - 4:45 PM; a total of 9.75 hours. The Nursing flow sheet dated 6/21/16 evidenced the next shift began at 8 PM; a total of 4 hours from 8 PM-12 AM. The combined hours for 6/21/16 totaled 20.75 hours.</p> <p>X. The Nursing flow sheet dated 6/21/16 evidenced the shift began at 8 PM and concluded on 6/22/16 at 7 AM; a total of 7 hours on 6/22/16. The Nursing flow sheet dated 6/22/16 evidenced the next shift was from 7 AM - 4:30 PM; a total of 9.5 hours. The Nursing flow sheet dated 6/22/16 evidenced the next shift began at 10 PM; a total of 2 hours from 10 PM-12 AM. The combined hours for 6/22/16 totaled 18.5 hours.</p> <p>Y. The Nursing flow sheet dated 6/23/16 evidenced the shift began at 10 PM and concluded on 6/24/16 at 7 AM; a total of 7 hours on 6/24/16. The Nursing flow sheet dated 6/24/16 evidenced the next shift was from 7 AM - 5:15 PM; a total of 10.25 hours. The combined hours for 6/24/16 totaled 17.25 hours.</p>			
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	<p>3. The clinical record for patient # 5 was reviewed on 7/6/16. Start of care date 11/6/10. The plan of care dated 5/24-7/22/16 contained orders for SN 6-10 hours a day, 3-5 days a week, Respite hours to be scheduled per parents' request. The record evidenced the agency provided SN services 6 days a week for 3 weeks, and failed to evidence a physician order was obtained for these extra visits.</p> <p>A. The record evidenced SN services were provided on 6/6, 6/7, 6/8, 6/9, 6/10, and 6/11/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/6-6/12/16.</p> <p>B. The record evidenced SN services were provided on 6/13, 6/14, 6/15, 6/16, 6/17, and 6/18/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/13-6/19/16.</p> <p>C. The record evidenced SN services were provided on 6/20, 6/21, 6/22, 6/23, 6/24, and 6/25/16 from 9 AM-5 PM for PA hours; a total of 6 days the week of 6/20-6/26/16.</p> <p>4. Clinical record #6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN 8-14 hours a day, 4-6 days</p>			

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	<p>a week for a total of 65 hours per week; respite hours as needed. The record evidenced the agency failed to provide 8-14 hours a day on 4/23, 5/7, 5/10, 5/14, 5/28, 6/4, and 6/18/16, and failed to evidence the physician was notified of the shorter hours provided.</p> <p>A. The Nursing Flow Sheet dated 4/23/16 evidenced the shift was from 7 AM - 2:15 PM, a total of 7.25 hours.</p> <p>B. The Nursing Flow Sheet dated 5/7/16 evidenced the shift was from 7 AM - 12:45 PM, a total of 5.75 hours.</p> <p>C. The Nursing Flow Sheet dated 5/10/16 evidenced the shift was from 9:45 AM - 5 PM, a total of 7.25 hours.</p> <p>D. The Nursing Flow Sheet dated 5/14/16 evidenced the shift was from 7 AM - 1:15 PM, a total of 6.25 hours.</p> <p>E. The Nursing Flow Sheet dated 5/28/16 evidenced the shift was from 6 AM - 11:30 AM, a total of 5.5 hours.</p> <p>F. The Nursing Flow Sheet dated 6/4/16 evidenced the shift was from 6:30 AM - 12:30 PM, a total of 6 hours.</p> <p>G. The Nursing Flow Sheet dated 6/18/16 evidenced the shift was from</p>			

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	<p>6:30 AM - 12:30 PM, a total of 6 hours.</p> <p>H. During interview on 7/6/16 at 2:20 PM, employee A (Nursing Supervisor) stated usually the parents come home and send our workers home early.</p> <p>5. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week fro 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to evidence a reason for the PRN visits, failed to evidence 3 visits were conducted from 2/17-2/21/16, and failed to evidence the physician was notified of the missed visits.</p> <p>A. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>B. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN) performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital</p>			

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	<p>signs of temperature, pulse and respirations.</p> <p>C. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>E. The Skilled Nursing Visit note dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated they did notice the vitals were not completed when the record was reviewed; and the PRN visits were if anything was needed past the ordered visits.</p> <p>G. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor (employee AA) handled this case, and it was a difficult family to get a hold of and the agency was not able to get into the home until 2/19, but this was not documented.</p>			

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	<p>H. During interview on 7/7/16 at 10:00 AM employee D (Assistant Clinical Manager) stated the patient was in the hospital, but this is not documented.</p> <p>I. The Lutheran Hospital Daily Progress Notes dated 2/15/2016 stated "Plan: D/C home. ... HHC [home health care] visits ordered."</p> <p>6. The clinical record for patient # 10 was reviewed on 7/6/16. Start of care date 9/8/08. The plan of care dated 5/22-7/20/16 contained orders for SN 5-8 hours a day, 4-6 days a week for 60 days, respite up to 480 hours a year. The record failed to evidence the agency provided 5-8 hours for 3 days from 5/22-6/22/16.</p> <p>A. The Nursing Flow Sheet dated 5/27/16 evidenced the shift was from 8:30 AM-12:30 PM for PA hours, for a total of 4 hours.</p> <p>B. The Nursing Flow Sheet dated 6/8/16 evidenced the shift was from 11:00 AM-2:30 PM for PA hours, then 2:30-6:30 PM for respite; for a total of 3.5 PA hours.</p> <p>C. The Nursing Flow Sheet dated</p>			

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	<p>6/22/16 evidenced the shift was from 12:35 PM-4:45 PM for PA hours, for a total of approximately 4-4.25 hours.</p> <p>D. During interview on 7/6/16 at 9:45 Am, employee A stated the agency combines the PA and Respite hours, but he saw how it's ordered, and had nothing to say.</p> <p>7. The agency's policy titled "Plan of Care," # C-580, revised 07/01/07 stated "B. The Plan of Care shall be completed in full to include: ... 5. Type, frequency, and duration of all visits/services ... 15. Medical supplies and equipment required ... 23. Other appropriate items i.e. equipment and medical supplies. 24. All of the above items must always be addressed on the Plan of Care. ... C. If a physician refers a client under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan. The skilled assessment visit order will be documented on a Doctor's Order Form and mailed to the physician for signature. ... E. The Plan of Care/485 will be developed following the initial assessment ... I. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. ... K. The PRN orders</p>			

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	will be accompanied by a description of the client's needs that could warrant a visit."			

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N 0524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on observation, document review,</p>	N 0524	Director/Assistant Clinical Care	07/22/2016

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	<p>and interview, the agency failed to ensure the plan of care included a duration of services for 4 of 10 clinical records reviewed (# 3, 4, 5, and 6); and failed to ensure all durable medical equipment (DME) and hours for services and disciplines were on the plan of care for 2 of 10 clinical records reviewed (# 1, and 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/6/15. The plan of care dated 5/21-7/19/16 contained orders for skilled nursing (SN) 8-12 hours a day, 5-7 days a week for 60 days; and listed DME and Supplies of Trach supplies, suction machine and supplies, nebulizer with supplies, Oxygen concentrator with tubing and humidifier bottle, sterile water, enteral formula with feed bags and tubing, syringes, gloves, and stethoscope. The DME section failed to include the stander, and the plan of care failed to include respite hours were available and Pre-Authorized hours were 83 hours a week.</p> <p>A. During home visit on 6/29/16 at 9:00 AM with patient #1, DME observed in the home included a stander.</p> <p>B. During record review on 6/29/16,</p>		<p>Manager have reviewed the requirements on the 485. The Director sent an in service to all staff members on 7/22/16 as to the requirements on the 485 and the nurse's responsibility of reporting any changes to the nursing supervisor. During home supervisory visits all sections of the 485 will be reviewed in the home with the present nurse and/or caregiver for accuracy. If new orders are indicated they will be obtained.</p>	

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	<p>respite hours were documented as having been provided on 5/21, 5/22, 5/27, 5/31, 6/8, 6/15, and 6/19/16.</p> <p>2. During interview on 6/29/16 at 1:10 PM, employee A (Nursing Supervisor) stated he was not sure when patient #1 received a stander, but the respite hours should be on the plan of care, and if staff are providing respite hours they should be marking them as "waiver" hours.</p> <p>3. Clinical record # 3 was reviewed on 7/6/16. Start of care date 4/8/12. The plan of care dated 5/11-7/9/16 contained orders for skilled nurse (SN) 8-21 hours a day, 5-6 days a week. The order for services failed to contain a duration.</p> <p>4. Clinical record # 4 was reviewed on 6/29/16. Start of care date 7/8/10. The plans of care dated 3/11-5/9/16 and 5/10-7/8/16 contained orders for SN 5-10 hours a day, 1-4 days a week. The orders for services failed to contain durations.</p> <p>5. Clinical record # 5 was reviewed on 7/6/16. Start of care date 11/6/10. The plan of care dated 5/24-7/16/16 contained orders for SN 6-10 hours a day, 3-5 days a week. The orders for services failed to contain a duration.</p> <p>6. Clinical record # 6 was reviewed on</p>			

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	<p>7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN 8-14 hours a day, 4-6 days a week for a total of 65 hours a week. The orders for services failed to contain a duration.</p> <p>7. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. The plan of care dated 2/17-4/15/16 contained orders for Home visits 3 times a week for 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to list which discipline was ordered.</p> <p>A. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated all the visits are skilled nurse visit since we did not have any Home Health Aide cases at that time.</p> <p>8. The agency's policy titled "Plan of Care," # C-580, revised 07/09/15 stated "B. The Plan of Care shall be completed in full to include: ... 5. Type, frequency, and duration of all visits/services ... 15. Medical supplies and equipment required ... 23. Other appropriate items i.e. equipment and medical supplies. ... K. The PRN orders will be accompanied by a description of the client's needs that could warrant a visit."</p>				

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N 0537 Bldg. 00	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on document review and interview, the agency failed to ensure the nurses provided services as ordered on the plan of care for 2 of 10 clinical records reviewed. (# 6, and 9)</p> <p>Findings include</p> <p>1. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN (skilled nurse) 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate Trach cuff for longer periods of time during the day; Assessment/Vitals: Temperature, Pulse, Respiration every 4 hours and PRN, blood pressure PRN, Review of symptoms: Assess respiratory, cardiovascular, integumentary, gastrointestinal, genitourinary, and musculoskeletal status every 4 hours and PRN, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the nurse failed to measure vital signs and perform assessments as ordered by the physician.</p>	N 0537	<p>Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders on the 485. Director/Assistant Clinical Care Manager have reviewed that the requirements are contained on the 485. During home supervisory visits all sections of the 485 will be reviewed in the home with the present nurse and/or caregiver for accuracy. If new orders are indicated they will be obtained Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be</p>	07/22/2016
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	<p>A. The Nursing Flow Sheet dated 4/26/16 from 6:30 AM-5:15 PM failed to evidence temperature and pulse were recorded at 3:00 PM.</p> <p>B. The Nursing Flow Sheet dated 4/29/16 from 6 AM-4:15 PM failed to evidence temperature, pulse, respirations, oxygen saturation, and Assessment of systems were recorded at 2:00 PM.</p> <p>C. The Nursing Flow Sheet dated 5/11/16 from 6:30 AM-5:30 PM failed to evidence temperature, pulse, and oxygen saturation were recorded at 3:00 PM.</p> <p>D. The Nursing Flow Sheet dated 5/27/16 from 6:30 AM-5:00 PM failed to evidence oxygen saturation was recorded at 3:00 PM.</p> <p>E. The Nursing Flow Sheet dated 6/14/16 from 6:30 AM-5:30 PM failed to evidence oxygen saturation was recorded at 3:00 PM.</p> <p>2. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis</p>		<p>performed with all discharged visit cases. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. This will also be reviewed with the admission of new visit cases and with the quarterly audits</p>				

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	<p>Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week fro 2 weeks, two times a week for 2 weeks, and then PRN. The record failed to evidence a reason for the PRN visits, failed to evidence 3 visits were conducted from 2/17-2/21/16, and failed to evidence the physician was notified of the missed visits.</p> <p>A. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>B. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN) performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital signs of temperature, pulse and respirations.</p> <p>C. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p>						

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	<p>E. The Skilled Nursing Visit note dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. During interview on 7/7/16 at 10:00 AM, employee A (Nursing Supervisor) stated they did notice the vitals were not completed when the record was reviewed; and the PRN visits were if anything was needed past the ordered visits.</p> <p>G. During interview on 7/7/16 at 9:50 AM, employee A (Nursing Supervisor) stated the previous Alternate Nursing Supervisor (employee AA) handled this case, and it was a difficult family to get a hold of and the agency was not able to get into the home until 2/19, but this was not documented.</p> <p>H. During interview on 7/7/16 at 10:00 AM employee D (Assistant Clinical Manager) stated the patient was in the hospital, but this is not documented.</p> <p>I. The Lutheran Hospital Daily Progress Notes dated 2/15/2016 stated "Plan: D/C home. ... HHC [home health care] visits ordered."</p>			

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N 0542 Bldg. 00	<p>3. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."</p> <p>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. Based on document review, and interview, the agency failed to ensure the Registered Nurses updated the plans of care and necessary revisions for 2 of 10 clinical records reviewed. (# 1, and 6)</p> <p>Findings include</p>	N 0542	The Director in conjunction with the Assistant Clinical Care Manager has reviewed and updated all active clients 485's to ensure that they are current and accurate. The Director was responsible and completed 100% of the client charts audited by 7/22/16. To follow up and ensure accuracy all sections of the 485	07/22/2016

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	<p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The plan of care dated 5/21-7/19/16 contained a diagnosis of respiratory failure, and had listed Trach supplies under durable medical equipment. In the section titled "Trach" the Trach size listed was 4.0 with an emergency Trach size 3.5 ordered.</p> <p>A. The record evidenced a physician's order dated 4/29/16 at 11 AM and stated "Change trach to a 3.5 PEDS [pediatric] Shiley uncuffed.-when available ... Have 3.0 PEDS uncuffed Shiley for back-up emergency." The current plan of care failed to include the trach size change.</p> <p>B. The un-signed Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 stated Tracheostomy size 4.0. This document failed to include the change of the trach size per physician order from 4/29/16.</p> <p>C. When asked for a copy of this document, employee C(Alternate Administrator) returned the document signed as 5/20/16, and failed to provide a copy of the document while it was un-signed.</p> <p>D. During interview on 6/29/16 at 12:00 PM, employee C stated she had the</p>		<p>will be reviewed with the current nurse and/or caregiver during each home supervisory visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly. Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. When flowsheets are returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders on the 485. 100% of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures are present in the client documentation</p>	

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	<p>nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>E. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>2. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN (skilled nurse) 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate Trach cuff for longer periods of time during the day, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the nurse failed to ensure the accuracy of the plan of care orders to the treatment sheets.</p> <p>A. The Patient Care and Treatment Schedules dated 4/18-4/24, 5/2-5/8, 5/9-5/15, 5/16-5/22, 5/23-5/29, 5/30-6/5, 6/6-6/12, and 6/13-6/19/16 stated "Inflate trach longer periods of time during day as tolerates ... Oximeter check-Sats [saturation] ... BID [twice daily]."</p> <p>3. The agency's policy titled "Plan of</p>			

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N 0544 Bldg. 00	<p>Care," # C-580, revised 07/01/07 stated "I. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on document review and interview, the agency failed to ensure the Registered Nurses (RNs) documented per policy for 1 of 10 records reviewed (# 1).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 was not signed by the nurse. When asked for a copy of this document, employee C(Alternate Administrator) returned the document signed as 5/20/16, and failed to provide a copy of the document while it was un-signed.</p> <p>A. During interview on 6/29/16 at 12:00 PM, employee C stated she had the</p>	N 0544	<p>100%of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature was not a common occurrence. 100% of signatures were present in client documentation. Staffing Coordinator and Clinical Care Assistant Manager have been instructed on their responsibility to adhere to staffed hours as ordered by the physician. At weekly staff meetings, during client case reviews, the client schedules are reviewed for agency compliance in adhering to physician orders. Over usages or underutilization in hours will be discussed and the primary physician will be alerted. Any changes per physician order willbe followed and schedules will be adjusted accordingly. Missed visit forms will accompany</p>	07/22/2016

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	<p>nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>B. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>C. During interview on 6/30/16 at 11:17 AM, employee C stated typically documents are to be signed when they are completed.</p> <p>2. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."</p>		<p>underutilization of hours and include documentation of reason. The Director is responsible for monitoring this weekly process. HPHC quarterly audits will be conducted and include documentation review to ensure the shift frequency is consistent with physician orders. If not, a missed visit document will be present and include the reasons why the shift was missed and the physician was notified. The Director is responsible for the completion and reporting of quarterly audits</p>	

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N 0600 Bldg. 00	<p>410 IAC 17-14-1(l)(3) Scope of Services Rule 14 Sec. 1(l)(3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not the employing agency, the employing agency shall keep a copy of the competency evaluation documentation in the home health aide's employment file.</p> <p>Based on document review and interview, the Administrator failed to ensure the employee files contained all required documents for 1 of 3 Home Health Aide (HHA) files reviewed. (N)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee files were reviewed on 7/7/16. Employee file N (HHA), date of hire 1/8/10, first patient contact date 7/1/10, and last patient contact date 9/16/15, failed to contain a copy of the Home Health Aide competency test. 3. During interview on 7/7/16 at 12:35 PM, employee A (Nursing Supervisor) stated the agency does not have a policy for employee files, only a check list. 4. The document titled "Homepointe Healthcare New Employee Requirements," no number, no date, stated "Home Health Aide Test ... Orientation sheets Signed Job Description." 	N 0600	<p>Administrator had Employee C (Alternate Administrator) sign appropriate job description that was missing from personnel file. Administrator/Director will audit all new hire, personnel files to ensure that all required documentation is present. All personnel files will be audited a minimum of annually. The Surveyor was shown that the agency has demonstrated that the other home health aide competency tests were present in their personnel files. Employee N was hired 1/8/10 and her competency test was present in her file for previous surveys and is now missing. Employee Nis no longer with the agency. HR/Director will ensure that all required documentation listed on the HPHC New Employee Requirements Checklist is present in the personnel files</p>	07/11/2016

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N 0608 Bldg. 00	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <ol style="list-style-type: none"> (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. <p>Based on document review and interview, the agency failed to ensure staff followed policies for clinical documentation fro 2 of 10 records reviewed (# 1, and 9); failed to ensure Pre-Authorized hours and Respite hours were clearly marked on the discipline flow sheets for 1 of 10 records reviewed (# 2); failed to ensure the accuracy of the plan of care orders to the treatment sheets for 1 of 10 records reviewed (# 6); failed to ensure the discharge summary included the reason for discharge and the</p>	N 0608	100%of client charts were audited for signatures of documentation for Comprehensive Assessments/Supervisory Visits by 7/22/16. Lack of signature is not a common occurrence. 100% of signatures are present in the client documentation. Nursing staff was in serviced on nursing documentation as it relates to orders on the 485. Nursing staff was also instructed that when performing PA hours to not check off the boxes (Reason for Respite)on the flowsheet as these are separate and different services. When flowsheets are	07/22/2016

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	<p>most recent discipline orders, and failed to evidence documentation for the admission assessment not being completed within 48 hours of referral for 1 of 10 records reviewed (# 9).</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 6/29/16. Start of care date 1/16/15. The Comprehensive Assessment/Supervisory Visit dated for the certification period 5/21-7/19 was not signed by the nurse. When asked for a copy of this document, employee C(Alternate Administrator) returned the document signed, and failed to provide a copy of the document while it was un-signed.</p> <p>A. During interview on 6/29/16 at 12:00 PM, employee C stated she had the nurse sign the document just now because he forgot to sign it and she thought this was just being brought to their attention.</p> <p>B. During interview on 6/30/16 at 11:15 AM, employee A (Nursing Supervisor) stated he had over looked signing the document.</p> <p>C. During interview on 6/30/16 at 11:17 AM, employee C stated typically documents are to be signed when they are</p>		<p>returned back to the office, the Director will ensure that they are randomly audited for accuracy with attention placed on whether or not the nurse is charting per the orders onthe 485. The Director reviewed 100% of client 485's to ensure accuracy related to client needs, duration of the order (POC for 60 days) and clearly marked and separated required hours for PA and Waiver. Physician orders were obtained as needed. Nursing staff and Clinical Care Mangers (CCM) have been reeducated on consistency and accuracy of orders to the 485 and all accompanying paperwork. When the CCM creates or revises a treatment sheet or any accompanying paperwork the nurse in the home will review for consistencyand accuracy. The Director will ensure continued compliance through 10% or 10charts audited quarterly. The Director in conjunction with the Assistant Clinical Care Manager has reviewed and updated all active clients 485's and any accompanying paperwork to ensure that they are current and accurate. The Director was responsible and completed 100% of the client charts audited by7/22/16. To follow up and ensureaccuracy, all sections of the 485 and any accompanying paperwork will be reviewed with the current nurse and/or caregiver during each home supervisory</p>	

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	<p>completed.</p> <p>2. Clinical record # 2 was reviewed on 7/6/16. Start of care date 7/25/14. The plan of care dated 5/10-7/8/16 contained orders for SN 7-16 hours a day, 4-6 days a week for 60 days, Waiver hours to be used at parents' discretion. The agency failed to ensure SN hours were clearly marked as Pre-Authorized (PA) hours or Respite/Waiver hours.</p> <p>A. The Nursing flow sheet dated 5/30/16 evidenced the shift began at 10 PM and concluded on 5/31/16 at 7 AM. The shift was marked as PA hours on the first page, and then as Respite hours on the last page.</p> <p>B. The Nursing flow sheet dated 6/5/16 evidenced the shift began at 10 PM and concluded on 6/6/16 at 7 AM. The shift was marked as PA hours on the first page, and then as Respite hours on the last page.</p> <p>C. The Nursing flow sheet dated 6/6/16 evidenced the next shift was from 7:30 AM - 5:10 PM, and was marked as PA hours on the first page, and respite hours on the third page. The Nursing flow sheet dated 6/6/16 evidenced the next shift began at 10 PM and was marked as PA hours on the first page, and</p>		<p>visit. If new orders are indicated they will be obtained. To ensure continued compliance, 10% or 10 charts will be audited quarterly. Currently HPHC has no active skilled nursing visit cases. Upon acceptance of a visit referral, in the future, the admitting nurse will receive a thorough orientation specific to the client. Physician orders and documentation requirements (including obtaining vital signs as part of the complete assessment process and following frequency orders) will be reviewed and the Director will oversee this process. An admission and weekly documentation chart review will occur on all future nursing visits by the Director. An audit will be performed with all discharged visit cases. Director has been reeducated on the requirements per policy for documenting the discharge of a client, specifically reason for discharge. Director/Assistant Clinical Care Manager will adhere to 48 hour referral to admission assessment and document any deviation from the admittance plan. The Director is responsible for ensuring that start of care regulations is met. Any deviation from physician's orders for required number of visits will be communicated to the physician. This will also be reviewed in the HPHC's audit process with the discharge and admission of new visit cases and with the quarterly audits.</p>	

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	<p>respite hours on the third page.</p> <p>D. The Nursing flow sheet dated 6/19/16 evidenced the shift began at 10 PM and concluded on 6/20/16 at 7 AM, and was marked as PA hours on the first page, and Respite hours on the third page. The Nursing flow sheet dated 6/20/16 evidenced the next shift was from 7 AM - 4:40 PM, and was marked as PA hours on the first page and Respite hours on the third page.</p> <p>3. The clinical record for patient # 6 was reviewed on 7/6/16. Start of care date 5/12/08. The plan of care dated 4/23-6/21/16 contained orders for SN 8-14 hours a day, 4-6 days a week, total of 65 hours a week; respite hours PRN (as needed); SN to Deflate trach cuff for longer periods of time during the day, and check oxygen saturation every 4 hours with assessment and PRN. The record evidenced the agency failed to ensure the accuracy of the plan of care orders to the treatment sheets.</p> <p>A. The Patient Care and Treatment Schedules dated 4/18-4/24, 5/2-5/8, 5/9-5/15, 5/16-5/22, 5/23-5/29, 5/30-6/5, 6/6-6/12, and 6/13-6/19/16 stated "Inflate trach longer periods of time during day as tolerates ... Oximeter check-Sats</p>			

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	<p>[saturation] ... BID [twice daily]."</p> <p>4. The clinical record for patient # 9 was reviewed on 7/6 and 7/7/16. Referral date 2/15/16. Start of care date 2/17/16. Discharge date 3/15/16. The plan of care dated 2/17-4/15/16 with diagnosis Respiratory Distress Syndrome of newborn, contained orders for Home visits 3 times a week for 2 weeks, two times a week for 2 weeks, and then PRN. The discharge summary failed to evidence the reason for discharge and failed to ensure the listed services included the most recent orders; and failed to evidence documentation for the admission assessment not being completed within 48 hours of referral.</p> <p>A. The record evidenced a physician order was received on 2/22/16 to decrease the SN visits to one time a week.</p> <p>B. The record failed to evidence documentation as to why the admission assessment was not completed until 2/19/16, and failed to evidence documentation as to why 3 visits were not completed the first week.</p> <p>C. The Pediatric Admission Assessment dated 2/19/16 failed to evidence the Registered Nurse (RN)</p>			

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	<p>performed a Respiratory Assessment, Gastrointestinal Assessment, and Vital signs of temperature, pulse and respirations.</p> <p>D. The Skilled Nursing Visit note dated 2/24/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>E. The Skilled Nursing Visit note dated 3/9/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>F. The Skilled Nursing Visit note dated 3/14/16 failed to evidence the RN obtained vital signs of temperature, pulse and respirations.</p> <p>5. The agency's policy titled "Discharge Summary," # C-820, effective date 07/01/07, stated "B. The Discharge Summary ... shall include, but not be limited, to: ... 7. Reason for discharge."</p> <p>6. The agency's policy titled "Clinical Documentation," # C-680, revised 02/09/15 stated "1. All skilled services provided by Nursing, Therapy, or Home Health Aide will be documented in the clinical record. ... 4. Telephone or other communication with clients, physicians, families, or other members of the health</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/07/2016
NAME OF PROVIDER OR SUPPLIER HOMEPOINTE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809		
(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	
	care team will be documented in Care Coordination Notes or other HomePointe HealthCare communication form. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period."				