

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/23/2015
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NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF SE INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 W EADS PKWY LAWRENCEBURG, IN 47025
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G 0000  Bldg. 00	<p>This visit was for the investigation of two (2) federal home health agency complaints.</p> <p>Complaints: IN 00181132 - Substantiated with related and unrelated findings.</p> <p>IN 00180705- Substantiated with related and unrelated findings.</p> <p>Survey Dates: 10-9, 10-13, 11-18, 11-19, 11-20, and 11-23-15.</p> <p>Facility #: IN003257</p> <p>Medicaid #: 200424030</p> <p>Facility census: Unduplicated skilled previous 12 months</p> <p>Skilled: 160</p> <p>HHA only : 312</p> <p>Personal Services: 0</p> <p>Total: 474</p> <p>Survey Sample:</p> <p>Clinical records reviewed with home visit: 6</p> <p>Clinical record review only: 6</p>	G 0000		
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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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	<p>Total:</p> <p>12</p> <p>Interim Healthcare of SE IN Inc, is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 11-23-15, for being found out of compliance with the Conditions of Participation 42 CFR 484.10 Patient's Rights; 484.14 Organization, Services, and Administration; and 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> <p>The Administrator was informed of the above-stated preclusion at the exit conference held on 11-23-15 at 4:30 PM.</p>			

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G 0100  Bldg. 00	<p>Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure the agency followed their policy to investigate complaints and document the existence of and resolution of the complaint for 3 of the complaints reviewed in the agency complaint logs (See G 107) and by failing to ensure the patient/patient representative was notified in writing of the disciplines that would furnish care and the frequency of proposed visits for 1 of 12 clinical records reviewed (See G 108).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.10 Patient Rights.</p>	G 0100	<p>484.10 CONDITION: PATIENT RIGHTS Credible Allegation of Compliance for this Condition</p> <p>1.The Administrator instructed office staff regarding the process for documentation and resolution of complaints, including the use of the Complaint Form, time frame for resolution and completion of the Complaint Log.</p> <p>2.The Administrator instructed staff on use and completion of The Notice Regarding Payment Form which is the form used at start of care to provide written notification to the patient of the disciplines and frequency of services to be provided by the agency. 3.The Regional VP, who reports directly to the Governing Body, will provide regular review of the above processes to ensure continued compliance</p>	01/06/2016	

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G 0107  Bldg. 00	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.  Based on record review and interview,	G 0107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP Investigate and distribute	01/06/2016

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	<p>the agency failed to ensure the agency conducted a thorough investigation, which met their own policy, of patients' complaints for 3 complaints in the 2015 complaint log (Patients #2, 13, and 14).</p> <p>The findings included:</p> <p>1. Review of policy "Complaints", last reviewed/revised 9-2-11, stated, "Interim HealthCare receives, investigates, and resolves complaints ... the process of receiving, investigating, and responding to complaints is in accordance with any applicable law, regulation, or contract requirement ... Definitions ... complaint: any expression of concern or dissatisfaction, or a protest regarding a circumstance ... resolved: the investigation of the complaint is completed and the Plan of Action is initiated ... Procedure: The Administrator/Manger or designee advises in-office and field employees to forward complaints to the Administrator/Manager or designee for follow-up ... the Administrator/Manager or designee establishes the circumstances surrounding the complaint ... determines if any immediate action is needed, and if so, takes the action and documents such ... complaints are deemed closed upon the signature of the Administrator/Manager or designee ... the</p>		<p>complaints &amp; resolutions Corrective Action: To improve and bring the agency into compliance with this Standard the Administrator/designee will provide education for all in-office staff regarding: 1.Review of regulation that the agency must investigate complaints made by the patient or the patient's family or guardian regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the agency and must document both the existence of the complaint and the resolution of the complaint; this includes the initiation and use of the Complaint Form and the completion of the Complaint Log. 2.Review of Complaint policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities form. 3.Review of policy and procedure for reporting, resolving, and documenting complaints. 4.Review of Policy and procedure for obtaining patient/responsibility party signature on the Homecare Admission Consent form to document that the Statement of Patient Rights and Responsibilities form was given to the patient and reviewed with the patient during the admission visit. 5.Educate employees responsible for QAPI as to process for quarterly review and use of</p>		

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	<p>Administrator/Manager communicates the finding of the complaint investigations to the governing body/owner ... the Administrator/Manager or designee maintains the complaint logs and records of individual complaints, the investigation, and status upon closing in the quality improvement files."</p> <p>2. Review of policy "Quality Improvement " , last reviewed/revised 8-27-04, stated, "The Administrator/Manager or designee provides the following information at least annually to the governing body/owner: A summary of findings or trends related to ... patient/family complaints."</p> <p>3. The agency 2015 complaint log was reviewed and contained the following complaints: a. complaint dated 7-25-15, from spouse of patient #2, alleged billing irregularities and HHA, employee G, was not providing services according to the plan of care for the HHA services. The spouse alleged employee G transported the patient to physical and occupational therapy services at a health care facility, then went outside to smoke, and had to be located by the facility staff. The agency investigation addressed the billing</p>		<p>complaints in quality improvement activities. 6.The Administrator/designee will monitor 100% of patient records for patients admitted to the agency to ensure that there is documentation of receipt of the Statement of Patient Rights and Responsibilities form until 100% compliance attained, then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 95%. 7.The Administrator/designee will communicate the findings of the complaint investigations to the governing body/owner on an annual basis and will maintain the complaint logs and records of individual complaints, the investigation, and status upon closing in the quality improvement files. 8.The 2015 Agency Evaluation, and PAG meeting, per agency policy will take place on 4/5/16, for the 2015 year. Review of the policy, "Quality Improvement", states that the Administrator provides the following information at least annually to the governing body/owner: A summary of findings or trends related to patient/family complaints. RESPONSE: For G107; the monitoring does not address the deficient practice to ensure compliance. What is the agency doing to ensure all complaints are thoroughly investigated for all allegations made? **Deficiencies have been</p>		

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	<p>irregularities only; the agency documentation failed to evidence an investigation of the allegation HHA, employee G, had not been available to provide hands on care for the patient during therapy sessions.</p> <p>b. complaint dated 8-8-15, from parent of patient #13, on agency complaint form, with attached email from person initially taking the complaint with several allegations, failed to identify the employee HHAs whom one of the allegations was made against " Mom stated ... she is tired of HHA ' s not knowing what they are supposed to do " The complaint investigation documentation failed to establish the circumstances surrounding the complaint and/or whether the allegations were credible and the investigation did not address all the allegations made in the complaint. The complaint data failed to evidence how the data obtained could be used by the agency for quality improvement activities.</p> <p>c. complaint dated 8-11-15, from patient #14, included allegations an agency HHA had stolen the patient ' s medication, clothes, and towels; HHA brought a laptop to patient ' s home and used it instead of providing care, patient asked HHA to go to patient ' s mother ' s home and pick up and cash a check every week, and HHA brought back \$100 of</p>		<p>corrected for all clients cited in the survey on or by 1/6/16. To ensure that all complaints are thoroughly investigated for all allegations made: The agency has provided education/training to all in office staff whom take complaints regarding:</p> <ol style="list-style-type: none"> <li>1.The review of the regulation regarding complaints.</li> <li>2.Review of IHC' policy and procedure for reporting, resolving, and documenting complaints , to ensure that eachcomplaint is being investigated for all allegations made in the future.</li> <li>3.The Administrator will include the following information at least annually to the governing body/owner, the addition of a"summary", of findings or trends related to Patient/family complaints to the <i>Office Self-Audit Tool</i> completed on an annual basis. The annual <i>Office Self-Audit Tool</i> is completed yearly prior to the PAG meeting in April ofthe following year.</li> </ol> <p>1.The complaint regarding Patient #2 was reviewed by the Administrator and Regional Vice President. The complaint dated 7/25/15 alleged billing irregularities and HHA, employee G was not providing services according to the POC for the HHA services, specifically that the client had been assisted to Outpatient therapy and was not available to provide hands on care for the patient during therapy</p>		

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	<p>\$200 on the check; patient sent HHA to store to buy items for patient and items on the receipt were not brought back to the patient; HHA had fallen asleep on duty. The agency investigation documentation evidenced " this was not the first complaint like this " and the HHA had " brought her kids with her to work " in patient ' s home. The complaint was signed as resolved on 8-13-15, and discipline of written warning was the plan of action identified. There were 2 discipline memos in employee I, HHA, identified in the complaint, personnel file. The first was a memorandum dated 8-11-15, indicating the agency would give the employee a written warning when able to contact employee by phone to come in to the agency. The second disciplinary memo, dated 8-13-15, indicated employee I had been terminated for no show, no call on 8-11-15. The complaint investigation failed to establish the circumstances surrounding the complaint and/or whether the allegations were credible and the investigation did not address all the allegations made in the complaint. The complaint data failed to evidence how the data obtained could be used by the agency for quality improvement activities.</p> <p>4. On 11-119-15, at 10:00 AM, the</p>		<p>sessions. The complaint was investigated and the Administrator sent the nursing supervisor out to speak with the client and wife. It was agreed that employee G would be removed from the case and a new aide would be assigned. The HHA was supposed to be escorting the client to outpatient therapy at the local hospital under his Waiver authorization for Attendant Care. The HHA was not responsible for providing hands on personal care while client was receiving therapy services. The HHA task was to escort the client using public transportation to and from therapy. Client was happy with the resolution of the complaints and continued services with IHC. The Administrator documented resolution of this complaint on the complaint log dated 7/30/15.</p> <p>2. In regards to Client #13, the HHA resigned from the agency after being counseled by the Nursing Supervisor regarding the complaints received on 8/8/15.</p> <p>3. The Administrator re-educated all staff receiving complaints to thoroughly investigate all complaints and ensure that documentation reflects details of the investigation and the resolution. (See education training documents).</p> <p>4. In regards to Patient #14, the HHA requested off of the case on July 14, 2015. She was removed from case and client was notified. On 8/11/15 the agency received a</p>				

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G 0108  Bldg. 00	<p>administrator/nursing supervisor, was interviewed and indicated the grievance investigations did not meet the agency policy and the investigations did not include data that could be tabulated and used by the agency to plan quality improvements activities. No further documentation was provided prior to exit.</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on record review and interview, the agency failed to ensure patient/patient representative were provided written notice in advance of the disciplines that would furnish care and the frequency of visits proposed to be furnished for 1 of 12 records reviewed (Patient #10).</p>			G 0108	<p>call from client #14, voicing complaints about her previous HHA. The Nursing Supervisor attempted to contact the HHA to discuss the complaint on 8/11/15. The HHA had no phone service and a message was left on device to call office before returning to work. No response was received. HHA was a no call/no show at other client on 8/12/15. The aide was terminated from agency for infraction of company policy.</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE Corrective Action: To improve performance and bring the agency into compliance with this Standard, the Administrator/designee will provide education to the professional staff regarding: 1.Regulation that the patient has</p>		01/06/2016

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	<p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Review of agency document, in start of care packet provided to patients upon admission, "Your Rights and Responsibilities as a Health Care Client " , copyright 2010, stated, "The client has the right to be informed in advance about the care to be furnished. The agency will inform the client in writing in advance of the disciplines that will furnish care and the frequency of proposed visits to be furnished. "</li> <li>2. The clinical record of patient #10, start of care 12-23-14, was reviewed and evidenced a form " Homecare Admission Consent Form " and a " Notice Regarding Payment Responsibility " , both signed by the patient on 7-30-14. A form " Financial Responsibility Agreement " was signed by the patient on 8-10-14. The consent forms failed to evidence the patient had been provided written notice, in advance of services furnished, of the disciplines and frequency of visits to be furnished. The plan of care was reviewed and evidenced the patient ' s plan of care order was for skilled nursing services, up to 7 hours per day, 7 days each week.</li> <li>3. On 11-23-15 at 3:00 PM, the nursing</li> </ol>		<p>the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.</p> <ol style="list-style-type: none"> <li>2.Regulation that the agency must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</li> <li>3.Regulation that the agency must advise the patient in advance of any change in the plan of care before the change is made.</li> <li>4.Policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities, the Notice Regarding Payment Responsibility form, and the Financial Responsibility form including care to be furnished, disciplines that will furnish the care, and the frequency of visits proposed to be furnished.</li> <li>5.Policy and procedure for advising patients in advance of any change in the plan of care before the change is made.</li> </ol> <p>Monitoring: The Administrator/designee will review 100% of new admission paperwork for completion of documents with a focused review of evidence that all patients have been provided with the Consent Form, Statement of Patient Rights and Responsibilities form and the Notice Regarding Payment Responsibility form, including information on care to be furnished, disciplines that will</p>	

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G 0122 Bldg. 00	<p>supervisor was unable to locate documentation the patient had been notified in writing of the disciplines that would furnish care and the frequency of proposed visits to be furnished.</p> <p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION</p> <p>Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure the organizational chart identified the names of the people holding positions on the organization</p>	G 0122	<p>furnish care, and the frequency of visits proposed to be furnished until the end of the corrective period, and then 10% or at least 5 records will be reviewed quarterly to maintain compliance within 95%. RESPONSE: For G108; the plan of correction indicated a goal of 95%. Any citation of one is deficient practice. The Administrator/designee will review 100% of new admission paperwork for completion of documents with a focused review of evidence that all patients have been provided with the Consent Form, Statement of Patient Rights and Responsibilities form, and the Notice Regarding Payment Responsibility form, including information on care to be furnished, disciplines that will furnish care, and the frequency of visits proposed to be furnished until the end of the corrective period, and then 10% or at least 5 records will be reviewed quarterly to maintain compliance of 100%.</p> <p>484.14 CONDITION: ORGANIZATION, SERVICES, AND ADMINISTRATION Credible Allegation of Compliance for this Condition 1.The Regional VP, who reports to the Governing Body, ensured that an updated Organization Chart, including in-office staff</p>	01/06/2016

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	<p>chart (See G 123); failing to ensure personnel policies were implemented for all agency personnel (See G 141); failing to ensure care was coordinated between agency personnel (See G 143); and failing to ensure care was coordinated between the agency and separately licensed or other providers rendering services to agency patients (See G 144).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.14: Organization, Services, and Administration.</p>		<p>names and their titles, is present and complete.</p> <p>2.The Regional VP reviewed with the Administrator the personnel policies regarding health screenings and TB testing. The Administrator instructed HR staff in the office of the required health screening and TB testing that must be completed prior to the assignment of staff to patient care.</p> <p>3.The Regional VP reviewed with the Administrator the policies regarding care coordination between disciplines and between other agencies providing care to our patients. It was determined that at least every 60 days, or more frequently as changes in patient's care dictates, care coordination between disciplines and/or between the agency staff and other providers caring for our patients will be documented in the clinical record. This was implemented immediately and the Administrator/designee is responsible to provide additional education to field staff on this issue.</p> <p>4.The Regional VP will provide regular review of the above issues to ensure continued compliance.</p>	

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G 0123  Bldg. 00	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable.</p> <p>Based on record review and interview, the administrator failed to ensure the Organizational Chart included the name of the employees under the title/position for 1 of 1 agency.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>On 10-12-15, the organizational chart was provided by the administrator. The organizational chart provided indicated titles/positions but failed to include the name of employee under the title/position.</li> <li>On 10-12-15, at 3:30 PM, the administrator disagreed the organization chart must have the names of people holding the positions identified, but could not explain how anyone could accurately identify the people in the agency chain of command without the names of the people holding management positions on the organization chart.</li> </ol>	G 0123	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION Corrective Action: To improve performance and bring the agency into compliance with this Standard the Administrator/designee will provide education to the professional staff regarding: The Administrator revised the organizational chart to include names as well as positions. 1.The Administrator/designee will update, post, and distribute the organizational chart through the employee portal to all employees, to include the names of person's responsible for each role in the organization. 2.The Administrator will post an updated organizational chart in each location. 3.Administrator/designee will update the organizational chart in a timely manner as changes in staff occur. 4.The Regional VP will monitor compliance through periodic review of the Organizational chart. RESPONSE: For G123 and G124; there is no corrective action identified. The agency has a completion date of 1/6/16, how this will be completed by this date? Correction action was</p>	12/23/2015			

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G 0125 Bldg. 00	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency.</p> <p>Based on record review, observation, and interview, the agency operated a branch location prior to the date of notification to/and approval from the Indiana State Department of Health (ISDH) and Center for Medicare and Medicaid Services (CMS) for 1 of 2 branch locations of the parent agency (Columbus branch).</p> <p>The findings included:</p> <p>1. ISDH documents dated 10-5-2015, evidenced the parent agency, 500 W. Eads Parkway, Lawrenceburg, IN, had submitted an application and worksheet for a branch office at 3200 N. National</p>	G 0125	<p>identified in the POC. The organization chart was updated by the Administrator to identify names and positions of agency employees. The completion date of G123 was 12-23-15 and all employees were provided a copy and each office location posted the updated organization chart in the office. G124 was not a cited deficiency on the SOD.</p> <p>484.14 ORGANIZATION, SERVICES, &amp; ADMINISTRATION Action: ISDH Form 53299 Instructions on timing state: "Timing of request ...An adequate assessment cannot be made for a location that is planned, but not operating. The questionnaire should be completed with respect to how the location is actually operating". The administrator has reviewed ISDH policy on opening a branch with Corporate office and phoned ISDH to assure that the process and paper work and process completed for opening a branch office was completed per instructions on form: 53209. Corporate attorney will be following up with this.</p>	01/06/2016

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	<p>Road, Columbus IN, and operated an approved branch in Scottsburg, Indiana.</p> <p>2. On 11-18-15 at 10:00 AM, observation of the branch office evidenced 2 employees present; employee J, administrative assistant employed in the Columbus branch, and employee K, a customer service representative, employed in the Scottsburg branch, assisting employee J on an ad hoc basis.</p> <p>3. During tour of the Columbus branch office on 11-18-15 at 11:00 AM, the clinical records room was observed and evidenced clinical record files. A list of active patients was provided by administrative assistant, employee J.</p> <p>4. During interview with employee J, on 11-18-15 at 10:05 AM, employee J indicated the branch had been open since November 2014, started billing for Columbus branch patient services on 11-14-14, had accepted patients for services through this branch location since November 2014, and had active patients whose clinical records were opened at this branch location as well as clients who were transferred to this branch location from the Scottsburg branch (15 active), and was supervised by the Administrator of the parent agency by</p>			

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	<p>visits to the branch, reports submitted by the branch to the parent agency, and through frequent telephone conferences. Employee J indicated the earliest start of care date for a patient whose services were started by the Columbus branch was 11-1-14 for patient #15 and #16</p> <p>5. During interview with administrator on 11-18-15, by telephone, at 10:30 AM, the administrator inquired " What are you doing at that location; Columbus is not an active branch? "</p> <p>6. On 11-18-15 at 2:30 PM, the administrator indicated the parent agency in Lawrenceburg was required procedure was to submit an application and worksheet for a proposed branch location, Columbus , accept active patients at the branch, provide care by branch employees, and then obtain approval from the Indiana State Department of Health and CMS to operate the branch. The administrator provided a list of active and discharged patients from the Columbus branch total of 29. When queried if the agency had received any notification from ISDH or CMS of approval to operate the Columbus branch, the administrator stated " No. "</p>			

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G 0133  Bldg. 00	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>Based on record review, observation, and interview, the administrator failed to ensure the agency organizational chart was complete for 1 of 1 agency; failed to ensure personnel policies were implemented for 2 of 6 direct care provider staff (employee F for tuberculosis evaluation) personnel files reviewed; and employee K for health physical); failed to ensure ISDH required forms were returned for 1 of 4 ISDH survey forms requested; failed to ensure 1 of 4 ISDH forms was completed to include agency census since last full survey for 1 of 4 ISDH forms presented at entrance to survey; and failed to ensure copies of home health aide visit notes were provided as requested for 1 of 5 records reviewed receiving home health aide services for whom copies of HHA visit notes were requested (Patient #2).</p> <p>The findings included:</p>	G 0133	<p>484.14(c) ADMINISTRATOR Corrective Action: The Administrator was given a list of requested documents from the surveyor at entrance and the Administrator returned these items to her. The Home Health Agencies Report and the patient census was included in the items given to the surveyor. (See attachments) To create performance improvement that demonstrates agency compliance to this Condition, the following has occurred 1.The Administrator revised the organizational chart to include names as well as positions for the organizational chart. 2.The Administrator/designee will update, post, and distribute the organizational chart through the employee portal to all employees, to include the names of person's responsible for each role in the organization. 3.The Administrator will post an updated organizational chart in each location. 4.Administrator/designee will update the organizational</p>	01/06/2016

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	<p>1. The organizational chart provided, dated 2012, indicated titles / positions but failed to include the name of employee under the title / position.</p> <p>2. ISDH form presented on 10-9 and 11-18-15, "Home Health Agencies Report", was not returned prior to exit of survey.</p> <p>3. ISDH form " Home Health Agency Survey and Deficiencies Report ", presented on 10-9-15, and provided again on 11-18-15, failed to evidence the administrator had provided the patient census, as requested, since the last full survey on 8-1-13.</p> <p>4. The home health aide visit notes of patient #2 were requested for the certification period reviewed; 6-21 to 8-19-15. The copies provided failed to include the week of 8-3 to 8-7-15 and 8-10 to 8-14-15.</p> <p>5. On 11-23-15 at 4:30 PM, the administrator indicated there have been management changes in 2015, such as a new alternate supervising nurse/alternate administrator, and the organizational chart did not provide the names of persons holding the positions.</p>		<p>chart in a timely manner as changes in staff occur. 5.The Administrator reviewed the personnel policies regarding health screenings and TB testing with HR staff in the office of the required health screening and TB testing that must be completed prior to the assignment of staff to patient care. 6.The Administrator will reorganize and re-direct the agency's ongoing functions by maintaining liaison with the Regional Vice President though weekly conference calls /face to face meetings throughout the corrective period.7.The Regional VP will be responsible to monitor compliance on an on-going basis.</p>	

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G 0141  Bldg. 00	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on record review and interview, the agency failed to implement its policy related to tuberculosis evaluation for 1 of 6 personnel files reviewed (employee K), and and failed to implements its policy related to health physicals for 1 of 6 personnel files reviewed (employee F).</p> <p>The findings included:</p> <p>1. Policy "Interim HealthCare Health Screening Policy", revised 9-2009, was reviewed and stated, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact The exam will be sufficient in</p>	G 0141	<p>484.14(e) PERSONNEL POLICIES Corrective Action: To improve performance and bring agency into compliance, Interim will follow the Centers for Disease Control and prevention guidelines for administering the tuberculin skin test. These guidelines are the "Core Curriculum on Tuberculosis: What the Clinician Should Know", Fifth Edition (2011). To bring the agency into compliance with this Standard, the Administrator/designee will take the following actions: 1.In-service all nurses who perform TB skin tests on Chapter 3, pages 45-72, Testing for Tuberculosis Infection and Disease, of the, "Core Curriculum for Tuberculosis: What the Clinician Should Know", Fifth Edition (2011). 2.The Administrator reviewed the personnel policies regarding health screenings and TB testing with HR staff in the office of the required health screening and TB</p>	01/06/2016

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	<p>scope to prevent the spread of infectious and communicable diseases to patients."</p> <p>2. Policy "Interim HealthCare Health Screening Policy", revised 8-2009, was reviewed and stated, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact The exam will be sufficient in scope to prevent the spread of infectious and communicable diseases to patients."</p> <p>3. " Guidelines for Preventing the Transmission of <i>Mycobacterium tuberculosis</i> in Health -Care Settings " , Volume 54, Page 46, Recommendations and Reports-17, 2005, was reviewed and stated " The tuberculin skin test should be read by a designated, trained health care worker 48-72 hours after the tuberculin skin test is placed. If the tuberculin skin test was not read between 48-72 hours, ideally, another tuberculin skin test should be placed as soon as possible and read within 48-72 hours. "</p> <p>4. The personnel file of employee K was reviewed and evidenced the HHA was</p>		<p>testing that must be completed prior to the assignment of staff to patient care. 3.The Administrator/designee has completed a focused review of all personnel health records to assure time/date/and signatures are on tuberculosis forms and the presence of health screenings. For those employees with incomplete files, a repeat TB test will be administered and properly documented in the employee's file and/or a health screening will be completed.</p> <p>4.Administrator/designee will conduct a focused review audit of 100% of personnel records to ensure that health files are current, timed, and dated appropriately. 5.Monitoring will continue for 100% of newly hired employees until 100% compliance is maintained for 30 days and then 10% or at least 5 records will be reviewed quarterly to maintain compliance within 95%. RESPONSE: For G141; 95% completion? To improve performance and bring InterimHealthcare into compliance, Interim will follow the Centers for Disease Controland prevention guidelines for administering the tuberculin skin test. These guidelines are the "Core Curriculum on Tuberculosis: What the Clinician Should Know", Fifth Edition (2011). To bring the agency into compliance with this Standard, the</p>		

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	<p>hired on 5-1-13 with first date of patient contact 5-4-13. A physical examination in the file, dated 2-26-14, was signed by a physician's assistant.</p> <p>5. Personnel file F, home health aide, date of hire 9-12-12, with direct patient contact 11-12-12, was reviewed and evidenced a TB skin test report with date of administration of 6-4-14, date of reading 6-6-14, results 0 mm. The report failed to evidence the times administered and read.</p> <p>6. On 11-23-15 at 3:30, the administrator verified the above findings and indicated agency policy had not been followed.</p>		<p>Administrator/designee will take the following actions:</p> <p>1. In-service all nurses who perform TB skin tests on Chapter 3, pages 45-72, Testing for Tuberculosis Infection and Disease, of the, "Core Curriculum for Tuberculosis: What the Clinician Should Know", Fifth Edition (2011).</p> <p>2. The Administrator reviewed the personnel policies regarding health screenings and TB testing with HR staff in the offices. Health screenings and TB testing must be completed prior to assignment of staff to perform direct patient care.</p> <p>3. The Administrator/designee has completed a focused review on all personnel health records to assure time/date/and signatures are on tuberculosis forms and the presence of health screenings. For those employees with incomplete files, a repeat TB test will be administered and properly documented in the employee's file and/or a health screening will be completed.</p> <p>4. Administrator/designee will conduct a focused review audit of 100% of personnel records to ensure that health files are current, timed, and dated appropriately. Monitoring will continue through the Quarterly clinical record review process.</p> <p>5. Monitoring will continue for 100% of newly hired employees until 100% compliance is</p>		

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G 0143 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on record review and interview, the agency failed to ensure all home health aides reported a change in the patient's condition to the supervising nurse for 1 of 3 patients who received home health aide services only (Patient #1).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Agency policy "Coordination of Care/Services " , dated 8-25-06, stated, "Interim HealthCare maintains regular communication with the patient/client and with others providing patient/client services. Actions and goals of Interim HealthCare Services are complimentary and reflect cooperative care planning ... the director establishes processes to document coordination of care/services in the patient/client. "</li> <li>Review of patient #1's clinical record</li> </ol>	G 0143	<p>maintained for 30 days. And then, 10%, or at least 5 records, will be reviewed quarterly to maintain compliance of 100%.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES Corrective Action: To improve performance and bring the agency into compliance with this Standard the Administrator/designee will provide education to the following: 1.The Administrator/designee will provide education to all staff regarding Interim Policy: Coordination of Care/Services 2.The Administrator/designee will provide education to all professional staff in the following: a. Care coordination will occur with each discipline assigned to provide care at least every 60 days or more frequently if changes in the patient's condition dictate and it is to be documented in the clinical record. b. Care coordination will occur with other health providers that provide care to our patients at least every 60 days or more frequently if changes in the patient's condition dictate and documented in the</p>	01/06/2016

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	<p>evidenced a start of care date of 9-11-12, The clinical record contained a physician's plan of care for the certification period 4-29 to 6-27-15 with order for home health aide services only up to 4 hours each day, 5 days a week for 9 weeks to "assist/perform personal care/ADLS/IADLs/keep patient's environment safe, clean, and odor free, HHA is to call RN for any changes or concerns in patient's condition. A comprehensive assessment dated 4-24-15, was reviewed and evidenced patient's integumentary system was "within normal limits."</p> <p>3. Patient #1 indicated not being able to recall the date the outpatient ingrown toenail removal procedure was performed, but indicated it was in May or early June 2015. The patient stated the toenail bed healed without complication, and the HHA assigned had seen the toe and the bandage after the procedure was performed (dressing on approximately 1 week).</p> <p>4. A comprehensive assessment dated 6-23-15, was reviewed and evidenced a narrative comment by the registered nurse, "infected toe nail - removed now healed." There was no further documentation of the site of the procedure to include the appearance of</p>		<p>clinical record.</p> <p>3. Home Health Aide personnel will be instructed in maintaining communication with the RN, including reporting all changes in the patient's condition to the RN Supervisor or to the Supervising RN in the office. Monitoring: Administrator/ designee will review a random selection of 10 charts per week for evidence of appropriate care coordination until 100% compliance is maintained for 30 days. Ongoing monitoring will continue through quarterly clinical record review.</p>	

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	<p>the toenail bed or the size and color of the toenail bed.</p> <p>5. Home health aide (HHA) visit notes were reviewed for the certification period and failed to evidence any documentation of the patient having a toenail removal procedure, notification to the supervising nurse or the agency nursing supervisor, or any description of a dressing, the condition of the affected area during bathing. The HHA failed to coordinate services with the supervising registered nurse.</p> <p>6. On 10-13-15 at 2:30 PM, the administrator confirmed the above findings and indicated the HHAs of the agency are trained to report any change in the patients condition, to include a procedure to remove a toenail and the HHA should have notified and documented the observation to the supervising nurse when the event occurred.</p>			

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G 0144 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on record review, observation, and interview, the agency failed to ensure agency personnel maintained timely liaison with another agency providing services to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care for 2 of 3 records reviewed of patients receiving services from another agency (Patients #2 and 6).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Agency policy "Coordination of Care/Services " , dated 8-25-06, stated, "Interim HealthCare maintains regular communication with the patient/client and with others providing patient/client services. Actions and goals of Interim HealthCare Services are complimentary and reflect cooperative care planning ... the director establishes processes to document coordination of care/services in the patient/client. "</li> <li>The clinical record of patient #2 was</li> </ol>	G 0144	<p>484.14(g) COORDINATION OF PATIENT SERVICES Corrective Action: To improve performance and bring the agency into compliance with this Standard: The Administrator/designee will provide education to all staff regarding care coordination with other health providers that provide care to our patients, at least every 60 days or more frequently if changes in the patient's condition dictate and to document this in the clinical record. Monitoring: Administrator/ designee will review a random selection of 10 charts per week for evidence of appropriate care coordination until 100% compliance is maintained for 30 days. Ongoing monitoring will continue through quarterly clinical record review.</p>	01/06/2016

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	<p>reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical record contained a plan of care for the certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to 8-19-15, was reviewed and evidenced an order for HHA services.</p> <p>b. Review of HHA visit notes during the certification period evidenced the HHAs transported the patient to a rehabilitation facility for physical and occupational therapy on the following dates:</p> <p>6-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-16-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-23-15 accompanied patient and</p>			

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	<p>assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>8-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>c. The plan of care, communication notes, case conference, supervisory visit notes were reviewed and failed to evidence coordination of care with the rehabilitation facility that provided physical and occupational therapy to the patient.</p> <p>3. During a home observation of a home health aide on 11-20-15 at 7:00 AM, patient #6 indicated because of the advanced state of multiple sclerosis, caregivers came in at night to provide care. The plan of care, case communication notes, and case conference notes were reviewed and failed to evidence coordination of care between the 2 providers.</p> <p>4. On 11-23-15 at 3:00 PM, the nursing supervisor indicated the clinical record communication notes, plan of care, and case conference notes failed to evidence coordination of care between the agency and a separately licensed agency providing care for patients #2 and #6. No further documentation was provided prior</p>			

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G 0156 Bldg. 00	<p>to exit.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on record review and interview, the agency failed to maintain compliance with this condition by failing to ensure that only patients whose needs could be met were continued on agency service for 3 of 12 clinical records reviewed (See G 157); failing to ensure visits were made as ordered on the physician's plan of care for 3 of 12 clinical records reviewed; and failing to ensure the plan of care order included a frequency of services greater than zero (0) for 1 of 12 records reviewed (See G 158); failing to ensure the plan of care accurately identified the start of care date and certification periods for 3 of 12 clinical records reviewed; failing to ensure the duties of home health aides were specified for 2 out of 5 records reviewed of patients receiving home health aide services; and failing to ensure the plan of care documented all the durable medical equipment in the home for 1 of 12 records reviewed (See</p>	G 0156	<p>484.18 CONDITION: ACCEPTANCE OF PATIENTS, POC, MED SUPERVISION Credible Allegation of Compliance for this Condition</p> <p>1.The Administrator is now reviewing all patient referrals to determine if agency services can meet patient's needs at time of referral. If patient needs cannot be safely and adequately met in the patient's home, with the resources available to the patient (agency, family and other support systems), the patient will not be admitted to the agency.</p> <p>2.The Administrator has instructed all staff involved in the referral and intake process regarding this standard.</p> <p>3.The Administrator has educated all staff responsible for scheduling patient care and RN Supervisory staff on the need to:</p> <p>a.provide care as ordered, b.document efforts to fill open visits/shifts, c.document on the Missed Visit/Shift form any missed visits or care provided less than what is</p>	01/06/2016

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G 0157 Bldg. 00	G 159).  The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.		ordered on the physician's plan of care, and d.Requirement to notify physician of care provided less than what is ordered. 4.The Administrator has instructed RN Supervisory staff responsible for review of Plans of Care completed by field staff on: a.the proper manner for documenting frequency and duration to ensure it does not include a frequency of zero, b.the use of ranges, c.that the phrase "up to" is not an acceptable frequency, d.documentation of all durable equipment specific to the patient's care, and e.Documentation of the correct SOC date (i.e., the date of the first billable visit/shift) and corresponding certification period. 5.The Regional VP will provide regular review of the above processes to ensure continued compliance.		
	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER				

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	<p>Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.</p> <p>Based on record review and interview, the agency failed to ensure patients were accepted and continued on service for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs could be met adequately by the agency in the patient's place of residence for 3 of 12 clinical records reviewed (Patients #1, 2, and 12).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Review of policy "Plan of Care", last reviewed/revised 8-27-04, stated, "Interim HealthCare provides care/service in accordance with the Plan of Care ... and standards of practice. "</li> <li>2. Review of policy " Admission to Home Care " , dated 5-14-10, stated, " An individual is admitted to home care only if: a) the needed care/service can be provided by appropriately qualified employees in a timely manner and at the level of intensity indicated by the individual ' s identified needs ... the</li> </ol>	G 0157	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPERVISION (NOTE – I deleted the word "Condition") Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place: Education: Education of all staff to policies and procedures: 1.Review of policy "Plan of Care" , "Admission to Home Care " , "Missed Visits". 2.Review of all patient referrals to determine if agency services can meet patient's needs at time of referral with prompt, timely initiation of services. If patient needs cannot be safely and adequately met in the patient's home, with the resources available to the patient (agency, family and other support systems), the patient will not be admitted to the agency. 3.Administrator/designee reviewed interoffice process of communicating missed visits/shifts to appropriate staff so that appropriate and supporting documentation can be completed and to: a.document efforts to fill open visits/shifts, b.document on the Missed Visit/Shift form any missed visits or care provided less than what is ordered on the physician's plan of care, and c.Requirement to notify physician</p>	01/06/2016

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	<p>location where the individual will receive care is within the geographic service area defined by the Office. "</p> <p>3. The clinical record of patient #1 was reviewed and evidenced a start of care 9-11-12, and diagnoses Friedrich ' s Ataxia and scoliosis, Medicaid payor. Three (3) plans of care and certification periods were reviewed: 4-29 to 6-27-15, 6-28 to 8-26-15, and 8-27 to 10-25-15.</p> <p>a. The plan of care contained an order for the certification period 4-29- to 6-27-15, for home health services up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>During the certification period the week of 5-11 to 5-17-15 the patient received 4 visits and 16 hours of HHA care rather than the ordered 5 visits and up to 20 hours of HHA care. The clinical record lacked documentation of the reason of the missed visit, or notification to physician. On 6-23-15, the comprehensive assessment by registered nurse, Employee F, noted " infected toenail -</p>		<p>of care provided less than what is ordered. 4. Medical orders can include specific range in visit frequency. 5. Ranges cannot include "0" as frequency PRN orders may be used with specified limits. 6. Alert physicians to all changes in visit frequency or changes in client's condition that indicate need to modify plan of care. Maintain documentation in clinical records that physician was notified of changes, missed visits or any other instances of need to modify plan of care. 7. Client assessments &amp; signed physician orders drive provision of appropriate care and services. Assessment of patients' medical, nursing, and social needs and evaluation of the agency's ability to meet those needs adequately. 8. Documentation clearly evidences that all care &amp; services were provided as ordered and any reasons of variation. 9. Identified problems and clear documentation of interventions, additional client/ family needs and how the needs were met or reasons why needs were unable to be met. 10. Case conferencing and collaboration. 11. When a plan of care cannot be met, Administrator/designee will be consulted along with physician and client to offer/facilitate change in provider/change in POC that will allow client needs to be met. If the client does not wish to change agencies, the agency</p>	

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	<p>removed now healed. " Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care.</p> <p>b. During the certification period 6-28 to 8-26-15, the plan of care order was for home health services (HHA) up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care. Review of HHA visit notes failed to evidence HHA visits during the PM from 7-17-15 daily throughout the certification period until 8-26-15, a total of 41 dates in which no HHA PM services were provided. No weekend hours of HHA service were provided. During this certification period, the patient had an ingrown toenail removal procedure, date unknown. The</p>		<p>will work with client, physician, and State to develop a plan for how the patient ' s needs will met in the absence of agency services. 12.The physician's Plan of Care for all current patients will be reviewed over the next 30 days to identify those records that are not in compliance with frequency and duration orders. For any record that is out of compliance, the physician will be contacted to obtain a Revision to the POC order for a change in frequency and duration that brings the record in compliance to current standards. Monitoring: The Administrator/designee will review 10 charts per week through the end of the corrective period for evidence of patient's needs can be adequately met by the HHA in patient's residence and for physician orders obtained for all interventions provided. Monitoring will continue through the Quarterly clinical record review process. RESPONSE: For G157; regarding #11 of yourplan, please describe how the state would be involved. The state is unable toconsult or provide direction. When a plan of care cannot be met, Administrator/designee will be consulted along with physician and client to discuss and offer a new agencyor update the POC accordingly to allow the client's needs to be met. If the client does not wish to changeagencies, the agency will work with client and</p>		

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	<p>HHA visit notes were reviewed and failed to evidence any documentation of the presence or absence of a dressing, the appearance of the foot when able to bathe or shower the patient, or notification to the supervising nurse of a change in the patient ' s condition related to having had a surgical procedure. A follow-up comprehensive assessment dated 6-23-15 evidenced " infected toenail removed now healed. " The nursing notes, communication notes, and physician orders were reviewed and failed to evidence the attending physician had been contacted regarding the change in condition and consulted for further orders.</p> <p>c. During the certification period 8-27 to 10-25-15, the plan of care order was for home health services up to 6 hours each day, 7 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " The HHA visit notes were reviewed and failed to evidence HHA had provided services of up to 4 hours during the day,</p>		<p>physician to develop a plan for how the patient's needs will be met in absence of agency services.</p> <p>For G157; #12, to clarify, were changes being made to frequencies based on an assessed need or based on staff needs? In regards to client #1, an order was obtained on 6-9-15 to increase services to 6 hours per day, 7 days per week. The POC dated 6-28-15 through 8-26-15 did not reflect the new order for increased hours. The change was noted on the 8-27-15 through 10-25-15 POC. #12 on POC states that the agency will review all POC's over the next 30 days to identify records that are not in compliance with frequency and duration orders. For any records found to have incorrect frequencies and duration due to change orders, as in the case of client #1, the Administrator/designee will ensure that the POC is updated with all change orders ensuring client's needs are being met.</p>	

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	<p>and up to 2 hours in the evening. The HHA visit notes were for 5 days each weekday only, 5 hours during the day. No PM hours were provided between 8-27-15 and 9-15-15, a total of 20 dates in the certification period with HHA visits not provided as ordered on the plan of care. No weekend hours of HHA service were provided. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient 's needs were met in the absence of agency services. The patient was discharged 9-15-15, per patient request, to transfer to another agency.</p> <p>4. The clinical record of patient #2 was reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical record contained a plan of care for the certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to</p>			

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	<p>8-19-15, contained an order for HHA services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>b. Review of the HHA visit notes failed to evidence HHA had provided services on 7-2, 7-3, 7-13, 7-20, 7-21, 8-3 to 8-7, and 8-10 to 8-14-15. HHA visit on 7-24-15 was for 6.5 hours, not 8 hours as ordered. Review of the communication notes and physician orders failed to evidence any documentation of the reason for the missed visits, short visit, notification to the attending physician of the agency failure to provide services as ordered, or how the patient ' s care needs were met in the absence of agency services. The date of discharge was 9-8-15, per patient request, to transfer to another agency.</p> <p>5. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15, diagnoses cerebral palsy,</p>			

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	<p>epilepsy, and intellectual impairment, Medicaid payor. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. " The first HHA visit note was dated 10-14-15, more than 2 months after the start of care date. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient ' s needs were met in the absence of agency services.</p> <p>6. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency has experienced a shortage of qualified staff over the last year, especially nurses and home health aides, and has had been unable to meet all the required visits according to the</p>			

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G 0158 Bldg. 00	<p>plan of care, especially in rural areas far from the Lawrenceburg agency.</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.</p> <p>Based on record review and interview, the agency failed to ensure services were provided as ordered by the physician on the plan of care for 3 of 12 records reviewed (Patients # 1, 2, and 12) and failed to include an order of frequency of services of 1 or greater for 1 of 12 records reviewed (Patient #4).</p> <p>The findings included:</p> <p>1. Review of policy "Plan of Care", last reviewed/revised 8-27-04, stated, "Interim HealthCare provides care/service in accordance with the Plan of Care ... and standards of practice. "</p>	G 0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPERVISION Corrective Action: The Administrator/designee will educate all professional and in-office staff on the following plan: 1.The proper manner for documenting frequency and duration to ensure it does not include a frequency of zero, 2.The use of ranges, 3.That the phrase "up to" is not an acceptable frequency, 4.The expectation that all Plans of Care will be corrected within the next 30 days with a physician's Revision order 5.The expectation that patient care is provided care as ordered, and if unable to do so, you must a.document efforts to fill open visits/shifts, b.document on the Missed Visit/Shift form any missed visits or care provided less than what is ordered on the physician's plan of</p>	01/06/2016

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	2. Review of policy "Variances from the Plan of Care/Service Plan " , last reviewed/revised 8-27-04, stated, "Interim HealthCare follows the plan of care/service plan as written ... Interim HealthCare takes precautions to avoid a missed visit, shift, or reduced hours ... patients/clients receive care/services that they require at the frequency and duration ordered ... If the office is unable to fill the visit/shift/hour requirement of a patient/client, then the DHCS or designee: contacts the patient/client/caregiver to reschedule the visit/shift to comply with the health care practitioner ' s orders ... If rescheduling is not an option, the designated employee identifies the patients/client ' s on-going needs during this unfilled visit/shift or reduced hours ... the designated employee identifies alternative measures/means to ensure the patient ' s/client ' s needs are met (e.g. family, friends, neighbors, group contractors able to fulfill the need) ... if alternative means cannot be identified and the visit/shift/hours are not filled but the missed care/services do not put the patient/client at risk, the DHCS or		care, and c.Requirement to notify physician of care provided less than what is ordered. 6.The Nursing Supervisor or designee tracks the frequency and reasons for missed visit/shift and periodically analyzes trends. If a pattern of missed visits/shifts or reduced hours develops, the Administrator/Nursing Supervisor will assess: staffing patterns and skill matching; recruiting/retention efforts; appropriateness of admission decisions (e.g. current staff unable to meet growing visit/shift needs); and geographic distribution of field employees versus patients/clients admitted. If a detection of trends in care/service variances develops, the Administrator/Nursing Supervisor will implement a corrective plan of action, up to and including transferring the patient to another agency or facility. 7.Every agency client will have an individualized plan of care that demonstrates medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. 8.If the Missed Visit is by a Home Health Aide then the Aide will report the missed visit to the office staff or Nursing supervisor who will notify the physician and complete the Missed Visit Communication Note. Monitoring: Administrator or designee will review 10 charts per week until the end of the corrective period for evidence of		

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	designee notifies all parties including the ordering health care practitioner (e.g. physician) ... and documents such ... If alternative means cannot be identified and the patient/client will be put at risk by not filling the visit/shift/hour requirement, then the DHCS or designee notifies all parties including any ordering health care practitioner ... that the patient/client must be temporarily transferred to another care/delivery location (e.g. ER, hospital, adult day care, another provider) for care services ... the DHCS or designee tracks the frequency and reasons for missed visit/shift or reduced hour variances and periodically analyzes trends ... if a pattern of missed visits/shifts or reduced hours develops, the DHCS assesses: staffing patterns and skill matching; recruiting/retention efforts; appropriateness of admission decisions (e.g. current staff unable to meet growing visit/shift needs); and geographic distribution of field employees versus patients/clients admitted ... If the DHCS detects trends of care/service variances, he/she ... develops and implements a corrective plan of action."		physician notification of all missed visits and physician orders obtained for all interventions provided. Monitoring will continue through the Quarterly clinical record review process. RESPONSE: For G158/N522; To clarify, a missed visit form does not excuse a provider from meeting the physician ordered plan of care if unable to staff visits. Please ensure awareness of this. The agency is aware that a missed visit form does not excuse provider from meeting the physician's ordered plan of care for each patient. An agency plan is in place to analyze trends. If a detection of trends in care/services variances develops, the Administrator/Nursing supervisor will implement a corrective plan of action up to and including transferring the patient to another agency or facility.	

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	<p>3. The clinical record of patient #1 was reviewed and evidenced a start of care 9-11-12, and diagnoses Friedrich ' s Ataxia and scoliosis, Medicaid payor. Three (3) plans of care and certification periods were reviewed: 4-29 to 6-27-15, 6-28 to 8-26-15, and 8-27 to 10-25-15.</p> <p>a. The plan of care contained an order for the certification period 4-29- to 6-27-15, for home health services up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient's environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " During the certification period the week of 5-11 to 5-17-15 the patient received 4 visits and 16 hours of HHA care rather than the ordered 5 visits and up to 20 hours of HHA care. The clinical record lacked documentation of the reason of the missed visit, or notification to physician. On 6-23-15, the comprehensive assessment by registered nurse, Employee F, noted "infected toenail - removed now healed." Interim physician order dated 6-9-15, approved by prior</p>			

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	<p>authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care.</p> <p>b. During the certification period 6-28 to 8-26-15, the plan of care order was for home health services (HHA) up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient's condition." Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care. Review of HHA visit notes failed to evidence HHA visits during the PM from 7-17-15 daily throughout the certification period until 8-26-15, a total of 41 dates in which no HHA PM services were provided. No weekend hours of HHA service were provided. During this certification period, the patient had an ingrown toenail removal procedure, date unknown. The HHA visit notes were reviewed and failed to evidence any documentation of the presence or absence</p>			

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	<p>of a dressing, the appearance of the foot when able to bathe or shower the patient, or notification to the supervising nurse of a change in the patient ' s condition related to having had a surgical procedure. The HHA did not follow the plan of care order to notify the nurse of any change in the patient's condition. A follow-up comprehensive assessment dated 6-23-15 evidenced " infected toenail removed now healed." The nursing notes, communication notes, and physician orders were reviewed and failed to evidence the attending physician had been contacted regarding the change in condition and consulted for further orders.</p> <p>c. During the certification period 8-27 to 10-25-15, the plan of care order was for home health services up to 6 hours each day, 7 days each week, for 9 weeks "to assist/perform personal care/ADLs/IADLs/keep patient's environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient's condition." The HHA visit notes were reviewed and failed to evidence HHA had provided services of up to 4 hours during the day,</p>			

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	<p>and up to 2 hours in the evening. The HHA visit notes were for 5 days each weekday only, 5 hours during the day. No PM hours were provided between 8-27-15 and 9-15-15, a total of 20 dates in the certification period with HHA visits not provided as ordered on the plan of care. No weekend hours of HHA service were provided. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient ' s needs were met in the absence of agency services. The patient was discharged 9-15-15, per patient request, to transfer to another agency.</p> <p>4. The clinical record of patient #2 was reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical record contained a plan of care for the certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to</p>			

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	<p>8-19-15, contained an order for HHA services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient's environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition."</p> <p>b. Review of the HHA visit notes failed to evidence HHA had provided services on 7-2, 7-3, 7-13, 7-20, 7-21, 8-3 to 8-7, and 8-10 to 8-14-15. HHA visit on 7-24-15 was for 6.5 hours, not 8 hours as ordered. Review of the communication notes and physician orders failed to evidence any documentation of the reason for the missed visits, short visit, notification to the attending physician of the agency failure to provide services as ordered, or how the patient's care needs were met in the absence of agency services. The date of discharge was 9-8-15, per patient request, to transfer to another agency.</p> <p>5. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15, diagnoses cerebral palsy, epilepsy, and intellectual impairment,</p>			

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	<p>Medicaid payor. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks "to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient's condition. "</p> <p>The first HHA visit note was dated 10-14-15, more than 2 months after the start of care date. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient's needs were met in the absence of agency services.</p> <p>6. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency has experienced a shortage of qualified staff over the last year, especially nurses and home health aides, and has had been unable to meet all the required visits according to the plan of care, especially in rural areas far</p>			

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G 0159 Bldg. 00	<p>from the Lawrenceburg agency. The administrator indicated the agency has made efforts to improve retention and increase recruitment, but was unable to provide an action plan.</p> <p>7. The clinical record of patient #4 was reviewed and evidenced a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide (HHA) services " 0W1, 2W8. " The HHA order failed to evidence a frequency of greater than zero (0) for the order regarding the first week of the certification period.</p> <p>8. On 11-23-15 at 4:30 PM, the administrator indicated not being aware the order on the physician plan of care did not include duration for the HHA services and included a frequency of " 0. "</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of</p>			

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	<p>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 record review, interview, and observation, the agency failed to ensure the plan of care and certification periods on the plan of care were correct for 2 of 12 records reviewed (Patients # 10 and 12) ; failed to ensure the duties of home health aides were specified for 3 out of 5 records reviewed of patients receiving home health aide services (Patients # 2, 6 and 12); and failed to ensure all necessary durable medical equipment and supplies were included on the plan of care for 1 of 12 records reviewed (Patient #4).</p> <p>The findings included:</p> <p>1. The clinical record of patient #10 was reviewed on 11-23-15, and evidenced a start of care date of 7-30-15, defined as the first billable visit, and contained a physician's plan of care for the certification period 9-23 to 11-21-15, with order for skilled nursing services up to 7 hours a day, 7 days each week, Medicaid payer. The clinical record evidenced a start of care comprehensive</p>	G 0159	<p>484.18(a) PLAN OF CARE Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place</p> <p>1. The Administrator/designee will conduct an in-service to all agency personnel who manage patient care. The following will be addressed:</p> <p>a. Care follows a Plan of Care that includes all patient medications, prescription and OTC, including those self-administered by the patient.</p> <p>b. All durable medical equipment and supplies specific to the patient will be included on the 485/Plan of Care in the section identified as Locator 14, Durable Medical Equipment and Supplies.</p> <p>c. The Medicare guidelines for OASIS assessment, plan of care and certification periods on the plan of care and documentation of the correct SOC date (i.e., the date of the first billable visit/shift) and corresponding certification period.</p> <p>d. Physician orders will be obtained for home health aide services to include the frequency and duration of services, the</p>	01/06/2016

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	<p>assessment dated 7-30-14. Review of visit notes evidenced the first billable visit, with care furnished, was on 8-11-14 by a registered nurse. The start of care should have been 8-11-14, and the certification periods should have been 8-11-14 to 10-9-14, 10-10- to 12-8-14, 12-9-14 to 2-6-15, 2-7 to 4-7-15, 4-8 to 6-6, 6-7 to 8-5, 8-6 to 10-4, and 10-5 to 12-3-15.</p> <p>2. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care established by a physician for the certification period 10-3 to 12-1-15 with order for HHA services 3 times each week. Review of visit notes evidenced the first billable visit, with care furnished, was on 10-14-15, by a HHA, more than 2 months after the start of care date. A start of care comprehensive assessment was performed on 8-4-15. The start of care date should have been 10-14-15, and the certification period should have been 10-14 to 12-12-15.</p> <p>3. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for</p>		<p>services needed (i.e., aide to assist with personal care, ADLs and IADLs), any special aide interventions (i.e., simple dressing changes, patient transportation, etc.).</p> <p>e.As within the RN's scope of practice, the RN will assign specific tasks to the aide via the Home Care Aide Assignment sheet. This will include the frequency that the tasks are to be performed.</p> <p>1.The RN Supervisor/designee will review all physician's Plans of Care and Home Care Aide Assignment Sheets to ensure that they are complete and accurate with the required information.</p> <p>Monitoring: Administrator/designee will perform a focused review of 10 charts per week during the corrective period for evidence of compliance with above items. Monitoring will continue through quarterly clinical record review.</p>		

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	<p>home health aide (HHA) services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>a. Review of the HHA care plan, updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided; perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client ' s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p>			

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	<p>b. Review of HHA visit notes during the certification period evidenced the HHAs performed duties on the following dates:</p> <p>6-22-15 complete bed bath, perineal care, hair care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>6-23-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>6-24-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body,</p>			

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	<p>provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>6-25-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion , cleaned kitchen, and washed dishes.</p> <p>6-26-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, assisted with range of motion 6-29 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral</p>			

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	<p>hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>6-30-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-1-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-6-15 complete perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the</p>			

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	<p>urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-7-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-8-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-9-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with</p>			

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	<p>transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-10-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-14-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-15-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted</p>			

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	<p>patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-16-15 perineal care, hair care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-17-15 prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion. The HHA visit note failed to evidence perineal care had been provided.</p>			

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	<p>7-22-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-23-15 perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-24-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with</p>			

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	<p>transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, cleaned patient ' s area, assisted with range of motion, and took patient outside for a picnic.</p> <p>7-27-15 partial bed bath, perineal care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-28-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-29-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with</p>			

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	<p>transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-30-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-31-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>8-3 to 8-7-15 and 8-10 to 8-14-15 copies of HHA visit notes were requested but not provided.</p> <p>8-17-15 partial bed bath, perineal care, hair care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for</p>			

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	<p>reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, cleaned client ' s area, made bed, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>8-18-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, made bed, and assisted with range of motion.</p> <p>8-19-15 complete bed bath, perineal care, prepared meals, served meals, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility,</p>			

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	<p>and assisted with range of motion.</p> <p>c. None of the HHA notes evidenced how often, or at what times, the patient was turned while in bed. None of the HHA visit notes documented any care rendered while patient was receiving physical and occupational therapy outside the home.</p> <p>d. The plan of care goal for HHA services was " the client will have personal needs and ADLs met, meals prepared, remain safe in the home and live in a clean and odor free environment with the assist of the HHA throughout the certification period. "</p> <p>e. The agency failed to specify on the physician plan of care orders the type and frequency of personal care and ADLs the home health aides were to provide. The physician plan of care failed to evidence an order for HHAs to accompany/transport patient #2 to therapy appointments.</p> <p>3. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or</p>			
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	<p>concerns in the patient ' s condition. "</p> <p>a. The HHA plan of care was reviewed and evidenced it was created on 8-4-15, and updated on 10-2-15. The duties delegated to the HHA were: " shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave as needed, nail care, hair care, skin care; observe for reddened or open areas, apply lotion, apply powder, keep skin clean and dry, assist with toilet commode, assist with ambulation-walker, wheelchair; assist with transfers, slide board, grab bars, gait belt, turn and position, range of motion lower extremities, vacuum client ' s area, dust client ' s area, clean client ' s bathroom, clean and straighten client ' s area, make client ' s bed, do client ' s laundry, change client ' s linen, clean client ' s kitchen, wash client ' s dishes, do not transport. " The HHA plan of care failed to specify active or passive range of motion.</p> <p>b. HHA visit note dated 10-14-15 was reviewed and evidenced the HHA performed the following: shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave with razor, nail care, hair care, skin inspected, lotion applied, powder applied, skin clean and dry, assisted with toilet commode, assisted with ambulation-walker, wheelchair, assisted with transfers, slide board, grab bars, range of motion,</p>			

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	<p>vacuumed client ' s area, dusted client ' s area, cleaned bathroom, cleaned and straightened client ' s area, made bed, did client ' s laundry, and changed client ' s linen.</p> <p>c. The plan of care goal for HHA services was " the patient ' s hygiene and personal care needs will be met this certification period with the assistance of the home health aide. The patient ' s home environment will be clean and odor free throughout the certification period. "</p> <p>d. The agency failed to specify on the physician plan of care orders the type and frequency of personal care and ADLs the home health aide was to provide.</p> <p>4. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency customarily has written, and sent to the physician for signature, HHA duties of " personal care, ADLs and IADLs, keep patient ' s environment safe, clean, and odor free. " The administrator was unable to define an accepted definition of personal care, and confirmed the physician ' s plan of care HHA orders did not provide a specific order related to the patient ' s hygiene needs for patient #2 and 12.</p> <p>5. The clinical record of patient #6 was reviewed and contained a plan of care with start of care date of 1-1-15 and a</p>			

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	<p>certification period of 10-28- to 12-26-15, diagnosis of multiple, neuromuscular dysfunction of bladder and bowel, mitral valve disorder, foley catheter. The physician's plan of care orders evidenced HHA services 1 time for 1 week, 2 times a week for 8 weeks "for personal care assistance, grooming, and ADLs, patient receives personal care and homemaking services through [name of agency]: HHA 10 hours per week and homemaker 8 hours per week." HHA visit notes for the certification period were reviewed and evidenced the HHA provided a partial or full bed bath at each visit, skin care, inspection of skin integrity and for signs of pressure or redness, turned the patient while in bed, assisted patient with hoier lift to electric wheelchair, dresses patient upper and lower body, provided incontinence care for fecal incontinence, and provided perineal care.</p> <p>6. The clinical record of patient #4 was reviewed and evidenced a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide and physical therapy. The plan of care medication orders evidenced " albuterol sulfate 2.5 mg/3mL, 1 vial nebu PRN 4 times a day inhalation for shortness of</p>			

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G 0173  Bldg. 00	<p>breath/wheeze. " The durable medical equipment and supplies on the plan of care evidenced " None " .</p> <p>7. During a home observation of a physical therapist on 11-19-15 at 2:00 PM, a nebulizer and disposable examination gloves were observed in the home. The patient indicated using the nebulizer for " breathing treatments. " The registered nurse failed to update the plan of care to include the nebulizer and the examination gloves.</p> <p>8. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated not being aware the nebulizer was not listed as durable medical equipment, and examination gloves should be on each plan of care for universal precautions and infection control purposes.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p>	G 0173	484.30(a) DUTIES OF THE	01/06/2016

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	<p>Based on record review, observation, and interview, the agency failed to ensure the registered nurse revised and updated the plans of care to include all durable medical equipment (Patient #4) and specific home health duties in relation to hygiene for 3 of 5 records reviewed receiving home health aide services (Patients # 2, 6, and 12).</p> <p>The findings included:</p> <p>1. The clinical record of patient #4 was reviewed and evidenced a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide and physical therapy. The plan of care medication orders evidenced " albuterol sulfate 2.5 mg/3mL, 1 vial nebu PRN 4 times a day inhalation for shortness of breath/wheeze. " The durable medical equipment and supplies on the plan of care evidenced " None " .</p> <p>2. During a home observation of a physical therapist on 11-19-15 at 2:00 PM, a nebulizer and disposable examination gloves were observed in the home. The patient indicated using the nebulizer for " breathing treatments. " The registered nurse failed to update the plan of care to include the nebulizer and</p>		<p>REGISTERED NURSE Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place:</p> <p>1. The Administrator/designee will conduct an in-service to all agency personnel who manage patient care. The following will be addressed:</p> <p>a)Care follows a Plan of Care that includes all patient medications, prescription and OTC, including those self-administered by the patient.</p> <p>b)All durable medical equipment and supplies, specific to the patient, will be included on the 485/Plan of Care in the section identified as Locator 14, Durable Medical Equipment and Supplies.</p> <p>c)The Medicare guidelines for OASIS assessment, plan of care and certification periods on the plan of care and documentation of the correct SOC date (i.e., the date of the first billable visit/shift) and corresponding certification period.</p> <p>d)Physician orders will be obtained for home health aide services to include the frequency and duration of services, the services needed (i.e., aide to assist with personal care, ADLs and IADLs), any special aide interventions (i.e., simple dressing changes, patient transportation, etc.).</p> <p>e)As within the RN's scope of practice, the RN will assign</p>				

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	<p>the examination gloves.</p> <p>3. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated not being aware the nebulizer was not listed as durable medical equipment, and examination gloves should be on each plan of care for universal precautions and infection control purposes.</p> <p>4. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for home health aide (HHA) services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>a. Review of the HHA care plan, updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided; perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail</p>		<p>specific tasks to the aide via the Home Care Aide Assignment sheet. This will include the frequency that the tasks are to be performed.</p> <p>2.The RN Supervisor/designee will review all physician's Plans of Care and Home Care Aide Assignment Sheets to ensure that they are complete and accurate with the required information.</p> <p>Monitoring Administrator or designee will perform a focused review of 10 charts per week during the corrective period for Updated care plans with all appropriate information included on the POC. Monitoring will continue through the Quarterly</p>	

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	<p>care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client ' s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p> <p>b. The registered nurse failed to update the plan of care orders to obtain specific orders for home health aide duties, to include patient hygiene, type and frequency of bathing.</p> <p>5. The clinical record of patient #6 was reviewed and contained a plan of care with start of care date of 1-1-15 and a certification period of 10-28- to 12-26-15, diagnosis of multiple, neuromusculare dysfunction of bladder and bowel, mitral valve disorder, foley catheter. The physician's plan of care orders evidenced HHA services 1 time for 1 week, 2 times a week for 8 weeks</p>				

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	<p>"for personal care assistance, grooming, and ADLs, patient receives personal care and homemaking services through [name of agency]: HHA 10 hours per week and homemaker 8 hours per week." HHA visit notes for the certification period were reviewed and evidenced the HHA provided a partial or full bed bath at each visit, skin care, inspection of skin integrity and for signs of pressure or redness, turned the patient while in bed, assisted patient with hoier lift to electric wheelchair, dresses patient upper and lower body, provided incontinence care for fecal incontinence, and provided perineal care.</p> <p>6. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. "</p> <p>a. The HHA plan of care was reviewed and evidenced it was created on 8-4-15, and updated on 10-2-15. The duties delegated to the HHA were: " shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave as</p>			

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G 0225 Bldg. 00	<p>needed, nail care, hair care, skin care; observe for reddened or open areas, apply lotion, apply powder, keep skin clean and dry, assist with toilet commode, assist with ambulation-walker, wheelchair; assist with transfers, slide board, grab bars, gait belt, turn and position, range of motion lower extremities, vacuum client ' s area, dust client ' s area, clean client ' s bathroom, clean and straighten client ' s area, make client ' s bed, do client ' s laundry, change client ' s linen, clean client ' s kitchen, wash client ' s dishes, do not transport. " The HHA plan of care failed to specify active or passive range of motion.</p> <p>b. The registered nurse failed to update the plan of care orders to obtain specific orders for the home health aide duties, to include patient hygiene and frequency of shower.</p> <p>7. On 11-23-15 at 2:30 PM, the alternate nursing supervisor verified the above findings.</p> <p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to</p>			

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	<p>perform under state law.</p> <p>Based on record review and interview, the agency failed to ensure all home health aides performed only duties ordered for the home health aide on the physician's plan of care for 1 of 5 records reviewed of patients receiving home health aide services (Patient #2).</p> <p>The findings included:</p> <p>1. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for home health aide (HHA) services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " Diagnoses included congestive heart failure, traumatic brain injury and scoliosis.</p> <p>a. Review of the HHA care plan, updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided;</p>	G 0225	<p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>To improve performance and bring the agency into compliance to this Standard, the following will take place:</p> <p>Corrective Action: The Administrator/designee will in-service all professional staff on the following:</p> <p>1.Physician orders will be obtained for home health aide services to include the frequency and duration of services, the services needed (i.e., aide to assist with personal care, ADLs and IADLs), any special aide interventions (i.e., simple dressing changes, patient transportation, etc.).</p> <p>2.As within the RN's scope of practice, the RN will assign specific tasks to the aide via the Home Care Aide Assignment sheet. This will include the frequency that the tasks are to be performed.</p> <p>3.The RN Supervisor/designee will review all physician's Plans of Care and Home Care Aide Assignment Sheets to ensure that they are complete and accurate with the required information.</p> <p>4.The Administrator/designee will instruct all registered nurse personnel who supervise home health aides to observe for implementation of the plan of care by the aide.</p> <p>5.The Administrator/designee will</p>	01/06/2016	

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	<p>perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client ' s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p> <p>b. Review of HHA visit notes during the certification period evidenced the HHAs transported the patient to a rehabilitation facility for physical and occupational therapy on the following dates: 6-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services 7-16-15 accompanied patient and assisted patient to use public transportation to attend physical and</p>		<p>instruct all home health aide personnel of the requirement to follow the plan of care for tasks such as turning, repositioning and range of motion exercises, and to perform only those duties that are checked on the Aide Care Plan Monitoring: The Administrator or designee will perform a focused review of 10 charts per week until the end of the corrective period for compliance to the above items. Monitoring will continue through the Quarterly clinical record review process.</p>	

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	<p>occupational therapy services 7-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-23-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>8-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>8-19-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>c. None of the HHA visit notes documented any direct care was provided during the transportation or the visits.</p> <p>d. The physician ' s plan of care failed to evidence an order for the HHA to transport the patient to a rehabilitation facility for physical and occupational therapy.</p> <p>e. On 11-23-15 at 4:30 PM, the</p>			

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G 0226 Bldg. 00	<p>administrator indicated the Medicaid prior authorization provided the home health aide could transport the patient out of the home for necessary services or physician appointments if the HHA services were necessary for mobility (use of wheelchair), incontinence care, safety, or other direct care provision. No further documentation was provided prior to exit.</p> <p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered.</p> <p>Based on record review and interview, the agency failed to ensure all home health aides performed only duties ordered for the home health aide on the physician's plan of care for 1 of 5 records reviewed of patients receiving home health aide services (Patient #2).</p> <p>The findings included:</p> <p>1. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care</p>	G 0226	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE To improve performance and bring the agency into compliance to this Standard, the following will take place: Corrective Action: The Administrator/designee will in-service all professional staff on the following: 1.Physician orders will be obtained for home health aide services to include the frequency and duration of services, the services needed (i.e., aide to assist with personal care, ADLs and IADLs), any special aide interventions (i.e., simple dressing changes, patient	01/06/2016

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	<p>established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for home health aide (HHA) services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " Diagnoses included congestive heart failure, traumatic brain injury and scoliosis.</p> <p>a. Review of the HHA care plan, updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided; perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client '</p>		<p>transportation, etc.). 2.As within the RN's scope of practice, the RN will assign specific tasks to the aide via the Home Care Aide Assignment sheet. This will include the frequency that the tasks are to be performed. 3.The RN Supervisor/designee will review all physician's Plans of Care and Home Care Aide Assignment Sheets to ensure that they are complete and accurate with the required information. 4.The Administrator/designee will instruct all registered nurse personnel who supervise home health aides to observe for implementation of the plan of care by the aide. 5.The Administrator/designee will instruct all home health aide personnel of the requirement to follow the plan of care for tasks such as turning, repositioning and range of motion exercises, and to perform only those duties that are checked on the Aide Care Plan Monitoring: The Administrator or designee will perform a focused review of 10 charts per week until the end of the corrective period for compliance to the above items. Monitoring will continue through the Quarterly clinical record review process. RESPONSE: For G226, the POC is not clear in describing how aides are aware not to perform tasks not assigned/ordered and how this is being monitored. All agency HHA's are oriented at time of hire</p>		

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	<p>s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p> <p>b. Review of HHA visit notes during the certification period evidenced the HHAs transported the patient to a rehabilitation facility for physical and occupational therapy on the following dates:</p> <p>6-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-16-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-23-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>8-17-15 accompanied patient and assisted patient to use public</p>		<p>regarding documentation and the requirement to follow the aide care plan in the home when performing tasks. Aides were reeducated on appropriate tasks to complete or not complete and necessity of appropriate documentation via a mailing dated January4, 2016. Educational materials were also posted to the employee corporate website on January 4, 2016. The Administrator/designee will perform ongoing weekly chart audits to ensure the aides are performing tasks as assigned/ordered on the careplan. Monitoring will continue throughthe Quarterly clinical record review process.</p>	

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G 0321 Bldg. 00	<p>transportation to attend physical and occupational therapy services</p> <p>8-19-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>c. None of the HHA visit notes documented any direct care was provided during the transportation or the visits.</p> <p>d. The physician ' s plan of care failed to evidence an order for the HHA to transport the patient to a rehabilitation facility for physical and occupational therapy.</p> <p>e. On 11-23-15 at 4:30 PM, the administrator indicated the Medicaid prior authorization provided the home health aide could transport the patient out of the home for necessary services or physician appointments if the HHA services were necessary for mobility (use of wheelchair), incontinence care, safety, or other direct care provision. No further documentation was provided prior to exit.</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency</p>				

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	<p>patient within 30 days of completing an OASIS data set.</p> <p>Based on record review and interview, the agency failed to ensure OASIS data was transmitted within 30 days of the M0090 date (date assessment completed) for 2 of 12 clinical records reviewed (Patients #3 and 8) and for 16% of non-duplicated OASIS data submitted between 4-1 and 9-30-15 for 27 of 168 patients for whom OASIS transmission was required no more than 30 days from the assessment.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. ISDH report for OASIS submission dated between 4-1 and 9-30-15 evidenced 27 of 168 (16%) non-duplicated submission records were submitted greater than 30 days after the M0090 date.</li> <li>2. The clinical record of patient #3, start of care 9-2-08, had a comprehensive assessment/OASIS M0090 dated 8-19-15. The agency OASIS submission report evidenced submission date of 9-22-15. The OASIS data was submitted greater than 30 days after the M0090 date.</li> <li>3. The clinical record of patient #8, start</li> </ol>	G 0321	<p>484.20(a) CONDITION: REPORTING OASIS INFORMATION Standard: Encoding Oasis data/Transmittal of Oasis Data Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place: The Administrator/designee will conduct an in-service for professional and in-office staff involved with the collection, encoding, and transmission of OASIS data on applicable regulations and policy for encoding and transmitting within 30 days of completing an OASIS data set. The Administrator/designee will develop and monitor a tracking system for ensuring all OASIS data sets are encoded and transmitted within 30 days, to include at least the following: 1.Tracking log 2.Phone f/u to clinicians for assessments not submitted to office within designated time frames Counseling of HHA staff who fail to collect, encode and transmit OASIS data within 30 days of completing an OASIS data set Monitoring: Administrator or designee will review 100% of transmissions of Oasis data on a weekly basis until</p>	01/06/2016			

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G 0334  Bldg. 00	<p>of care 2-6-11, had a comprehensive assessment/OASIS M0090 dated 3-19-15. The agency OASIS submission report evidenced submission date of 4-21-15. The OASIS data was submitted greater than 30 days after the M0090 date.</p> <p>4. On 11-23-15, at 4:30 PM, the administrator /nursing supervisor, was interviewed and indicated a corporate office in Ohio submits the OASIS comprehensive assessments. No further documentation was provided prior to exit.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on record review and interview, the agency failed to ensure the comprehensive assessment was performed no more than 5 days after the</p>	G 0334	<p>the end of the corrective period for evidence of timely transmission. Monitoring will continue through quarterly clinical record review.</p> <p>484.55(b)(1) CONDITION: COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely</p>	01/06/2016	

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	<p>start of care date for 2 of 12 records reviewed (Patients #10 and 12).</p> <p>The findings included:</p> <p>1. The clinical record of patient #10 was reviewed on 11-23-15, and evidenced a start of care date (defined as first billable visit) of 7-30-14, and contained a physician's plan of care for the certification period 9-23 to 11-21-15, with order for skilled nursing services Medicaid payer. The clinical record evidenced a start of care comprehensive assessment dated 7-30-14. Review of visit notes evidenced the first billable visit, with care furnished, was on 8-11-14 by a registered nurse. The comprehensive assessment was performed 12 days before the correct start of care date of 8-11-14.</p> <p>2. The clinical record of patient #12 was reviewed, and evidenced a start of care date (defined as first billable visit) of 8-4-15. The clinical record contained a plan of care established by a physician for the certification period 10-3 to 12-1-15 with order for HHA services. The clinical record evidenced a start of care comprehensive assessment dated 8-4-15. Review of visit notes evidenced the first billable visit, more than 2 months after the start of care date.</p>		<p>manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place: 1. The Administrator/designee will conduct an in-service for all professional staff involved with the comprehensive assessment of patients on the regulation and policy that the comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Monitoring: The Administrator/designee will audit 100% of all new admissions for timely comprehensive assessments until the end of the corrective period for evidence of comprehensive assessment performed no more than 5 days after the start of care date. Monitoring will continue through quarterly clinical record review.</p>				

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G 0339 Bldg. 00	<p>3. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, confirmed the above findings and indicated the agency customarily uses the date of the comprehensive assessment as the start of care date even when a billable visit, care furnished per physician order, was not furnished.</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on record review and interview, the agency failed to ensure the registered nurse performed a complete assessment and documented pertinent observation on the recertification comprehensive assessment for 1 of 1 clinical records reviewed of patients who had a procedure during the certification period reviewed (Patient #1).</p>	G 0339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place: 1.The Administrator/designee will conduct an in-service to all licensed professional personnel who conduct comprehensive assessments in the requirement that the Follow up assessment	01/06/2016

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	<p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Review of patient #1's clinical record evidenced a start of care date of 9-11-12, The clinical record contained a physician's plan of care for the certification period 4-29 to 6-27-15 with order for home health aide (HHA) services only.</li> <li>2. A comprehensive assessment dated 4-24-15, was reviewed and evidenced patient's integumentary system was "within normal limits."</li> <li>3. Patient #1 indicated not being able to recall the date the ingrown toenail removal procedure was performed, but indicated it was in May or early June 2015, while receiving home health aide services from the agency. The patient stated the toenail bed healed without complication, and the HHA assigned had seen the toe and the bandage after the procedure was performed (dressing on approximately 1 week).</li> <li>4. A comprehensive assessment dated 6-23-15, was reviewed and evidenced a narrative comment by the registered nurse, "infected toe nail - removed now healed." There was no further documentation of the site of the procedure to include the appearance of</li> </ol>		<p>must be conducted within the 5-day window of the last 5 days of the 60 day certification period.</p> <p>2.The RN Supervisor will ensure that the Recertification assessment is scheduled within Procura (the system used by the agency). 3.A weekly report will be run to identify the assessments due for the following week to ensure that a professional is scheduled to perform said assessment within the required time frame.</p> <p>Monitoring: Administrator or designee will perform a focused review of 10 charts per week until the end of the corrective period for accurate Oasis assessment, evidence of comprehensive assessment to include skin assessment, history of physician visits, and changes to the Plan of Care. Monitoring will continue through the Quarterly clinical record review process.</p> <p><b>RESPONSE: G339; Plan of correction does not address the deficiency cited. G339</b></p> <p>Update of the Comprehensive Assessment states that the assessment must be updated and revised the last 5 days of every 60 days beginning with the start of care date unless there is a beneficiary elected transfer, significant change in condition resulting in a new case mix assessment, or discharge and return to the same HHA during the 60 day episode. The agency completed the non-OASIS home</p>	

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N 0000  Bldg. 00	<p>the toenail bed or the size and color of the toenail bed.</p> <p>5. On 10-13-15 at 2:30 PM, the administrator confirmed the above findings and indicated the registered nurse should have made and documented observations of the size and condition of the "healed" toenail bed in the comprehensive assessment.</p> <p>This visit was for the investigation of two (2) state licensure home health agency complaints. This was an extended</p>	N 0000	<p>health aide only reassessment on 6-23-15 for the certification period of 6-28-15 to 8-26-15. This timeframe is compliant with the 5 day window rule. Client #1 was an unskilled client who received monthly supervisory nursing visits. The client had an ingrown toenail and contracted toe. The aide failed to inform the supervisor of this information and that he had a toe procedure. Bandage was removed and the toe was healed prior to the 6-23-15 nursing assessment visit. During the visit, the nurse asked client #1 about any recent physician visits and the rationale. Client #1 informed the nurse that he had an ingrown toenail and toe procedure but could not recall the date. Nurse documented that the toe was healed which indicates "a within normal limit" integumentary system. Aides were reeducated via a mailing dated January 4, 2016 regarding the requirement to report all changes in client condition to the nursing supervisor. Educational materials were also posted to the employee corporate website on January 4, 2016.</p>	

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	<p>survey.</p> <p>Complaints: IN 00181132 - Substantiated with related and unrelated findings.</p> <p>IN 00180705- Substantiated with related and unrelated findings.</p> <p>Survey Dates: 10-9, 10-12, 11-18, 11-19, 11-20, and 11-23-15.</p> <p>Facility #: IN003257</p> <p>Medicaid #: 200424030</p> <p>Facility census: Unduplicated skilled previous 12 months</p> <p>Skilled: 160</p> <p>HHA only : 312</p> <p>Personal Services: 0</p> <p>Total: 474</p> <p>Survey Sample:</p> <p>Clinical records reviewed with home visit: 6</p> <p>Clinical record review only: 6</p> <p>Total: 12</p>			

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N 0440 Bldg. 00	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>Based on record review and interview, the administrator failed to ensure the Organizational Chart included the name of the employees under the title/position for 1 of 1 agency.</p> <p>The findings included:</p> <p>1. On 10-12-15, the organizational chart was provided by the administrator. The organizational chart provided indicated titles/positions but failed to include the name of employee under the title/position.</p> <p>2. On 10-12-15, at 3:30 PM, the administrator disagreed the organization chart must have the names of people holding the positions identified, but could not explain how anyone could accurately identify the people in the agency chain of command without the names of the people holding management positions on</p>	N 0440	<p>Sec. 1. (a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. The administrator has in past years used the Interim Health Care organizational chart to indicate positions within the organization along with an employee roster identifying the names and titles of all individuals from each office location. This list is included in all Admission Packets as a letter explaining what services we provide and an employee roster for each of the offices and is given to all patients upon admission, and to all employees upon hire (see attached IHC marketing form). The surveyor was provided a copy of the Admission Packet which included this letter, Organizational chart and employee roster. In past surveys by IDH, this tag has not been cited. Corrective Action: To create performance improvement</p>	01/06/2016

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N 0444 Bldg. 00	<p>the organization chart.</p> <p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on record review, observation, and interview, the administrator failed to</p>	N 0444	<p>that demonstrates agency compliance to this Condition, the following changes will be made: The Administrator revised the organizational chart to include names as well as positions for ease of understanding the organizational chart per surveyor request. The Organizational Chart will be updated by the Administrator as changes in staff occur. Education: a. Administrator/designee provided educational program on the reporting structure to all staff via the employee portal and an updated Organizational chart to all employees. b. posting an updated organizational chart in each location Monitoring: The Organizational Chart will be updated by the Administrator as changes in staff occur. Agency review to include monitoring of postings in offices.</p> <p>1 c) An individual need not be a home health agency employee or be present full time at the home</p>	01/06/2016	

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	<p>ensure the agency organizational chart was complete for 1 of 1 agency; failed to ensure personnel policies were implemented for 2 of 6 direct care provider staff (employee F for tuberculosis evaluation) personnel files reviewed; and employee K for health physical); failed to ensure ISDH required forms were returned for 1 of 4 ISDH survey forms requested; failed to ensure 1 of 4 ISDH forms was completed to include agency census since last full survey for 1 of 4 ISDH forms presented at entrance to survey; and failed to ensure copies of home health aide visit notes were provided as requested for 1 of 5 records reviewed receiving home health aide services for whom copies of HHA visit notes were requested (Patient #2).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. The organizational chart provided, dated 2012, indicated titles / positions but failed to include the name of employee under the title / position.</li> <li>2. ISDH form presented on 10-9 and 11-18-15, "Home Health Agencies Report", was not returned prior to exit of survey.</li> <li>3. ISDH form " Home Health Agency Survey and Deficiencies Report " ,</li> </ol>		<p>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. Corrective Action: 1.The Administrator revised the organizational chart to include names as well as positions for ease of understanding the organizational chart per surveyor request. 2.The survey document on page 3 of 47, states that "employee K for health physical". Employee K has a health physical in the file dated 3/26/13. The surveyor did find a health physical of another employee that was signed by a PA however we were able to have the MD co-sign it and it was given to the surveyor who verbalized acceptance of it. 3.Employee F had a TB test that did not include the time of day on it in 6/2014. We have corrected this process and the employee had a negative TB in 6/2015. 4.The administrator was given a list of requested documents from the surveyor at entrance and provided her with these documents. The Administrator provided the documents requested and kept a duplicate copy for the survey record. The Home Health Facility Census was</p>		

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	<p>presented on 10-9-15, and provided again on 11-18-15, failed to evidence the administrator had provided the patient census, as requested, since the last full survey on 8-1-13.</p> <p>4. The home health aide visit notes of patient #2 were requested for the certification period reviewed; 6-21 to 8-19-15. The copies provided failed to include the week of 8-3 to 8-7-15 and 8-10 to 8-14-15.</p> <p>5. On 11-23-15 at 4:30 PM, the administrator indicated there have been management changes in 2015, such as a new alternate supervising nurse/alternate administrator, and the organizational chart did not provide the names of persons holding the positions.</p>		<p>included in the items returned to the surveyor on 10/13/2015 and again on 11/18/2015. The Administrator/designee did not receive a copy of the form Home Health Agency Survey and Deficiencies Report on 10/9/15 but did receive one on 11/18/2015 that was returned to the surveyor. The HHA Geographic Area served was returned on 10/13/15 and 11/18/15. (Attached)</p> <p>5. Surveyor was given an updated census on 10/13/2015 and on 11/18/2015.</p> <p>6. Patient #2 Visit notes: the surveyor was given a copy of the Missed Visit documentation for patient #2 for 7/3/15, 7/21/15, 8/3/15 to 8/7/15, 8/10/15 to 8/14/15 on 11/23/15. (See Attached).</p> <p>7. The Letter to patient in all Admission packets was kept up to date as to names of persons holding positions in the organization. (attached)</p> <p>8. The Surveyor was given a copy of a letter from Kelly Hemmelgarn dated 8/17/15 confirming receipt of notice and the name of Liese Cox as Alternate Administrator and Nursing supervisor. (Attached).</p> <p>To create performance improvement that demonstrates agency compliance to this Condition, the following changes to agency processes will be made:</p> <p>1. The Administrator revised the</p>		

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			<p>organizational chart to include names as well as positions for ease of understanding the organizational chart per surveyor request.</p> <p>2.The Administrator will report the agency's ongoing functions by maintaining liaison with the Regional Vice President though weekly conference calls or face to face meetings to discuss agency ongoing functions throughout the corrective period.</p> <p>To improve performance and bring the agency into compliance with this Standard, the agency will take the following action: The Administrator/designee has completed a focused review on all personnel health records to assure time/date/ and signatures are on tuberculosis form has been completed correctly or repeated. Completed 12/28/2015</p> <p>Education: 1. The Office nursing staff has been re-educated on: a. Policy "Interim HealthCare Health Screening Policy", revised 9-2009, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact The exam will be sufficient in scope to prevent the spread of infectious</p>	

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N 0456 Bldg. 00	<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 record review and interview, the administrator failed to ensure the quality assessment performance improvement (QAPI) program monitored complaints for trends for 1 of 1 agency.</p>	N 0456	<p>and communicable diseases to patients." b. The polices and procedure for Interim Health Care Health Screening Policy revised 9-2009 and the "Core Curriculum on Tuberculosis" that is stated as reference in our policy, was reviewed with all in- office nurse staff responsible for administering TB tests: " The tuberculin skin test should be read by a designated, trained health care worker 48-72 hours after the tuberculin skin test is placed. If the tuberculin skin test was not read between 48-72 hours, ideally, another tuberculin skin test should be placed as soon as possible and read within 48-72 hours.</p> <p>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.</p>	12/30/2015

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	<p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Policy "Complaints", last reviewed/revised 9-2-11, was reviewed and stated, "Interim HealthCare receives, investigates, and resolves complaints ... the Administrator/Manager communicates the finding of the complaint investigations to the governing body/owner ... the Administrator/Manager or designee maintains the complaint logs and records of individual complaints, the investigation, and status upon closing in the quality improvement files."</li> <li>2. Policy "Quality Improvement ", last reviewed/revised 8-27-04, was reviewed and stated, "The Administrator/Manager or designee provides the following information at least annually to the governing body/owner: A summary of findings or trends related to ... patient/family complaints."</li> <li>3. Review of the governing body meeting minutes in 2014 and 2015 failed to evidence a summary of findings and/or trends related to patient/family complaints had been presented to the governing body at least annually.</li> <li>4. Review of the QAPI program failed to evidence complaints had been</li> </ol>		<p>(3) Improve patient care. a.The deficiency states that the agency failed to follow the policy to investigate complaints and document the existence of and resolution of the complaint for 3 of the complaints reviewed in the 2015 agency complaint logs. The agency did investigate and document each of the 3 complaints according to the Interim HealthCare policy, "Complaints, dated 9/2/11". The documentation of the complaints was given to the surveyor on 10/13/15, and was found to be unacceptable to the surveyor.</p> <p>b. In the Interpretive Guidelines it states, "If resolution of the problem was not possible, the actions that were attempted and the outcomes should be documented by the HHA". c.The 2015 Agency Evaluation, and PAG meeting, per agency policy will take place on 4/5/16, for the 2015 year. The Administrator will present a summary of the findings or trends related to patient/family complaints for 2015 at the annual meeting to the governing body/owner. a.The deficiency states that the agency failed to follow the policy to investigate complaints and document the existence of and resolution of the complaint for 3 of the complaints reviewed in the 2015 agency complaint logs. The agency did investigate and document each of the 3 complaints according to the</p>	
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	<p>monitored/tracked for emerging or continuing trends.</p> <p>5. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated the governing body had not been provided a summary of findings related to complaints and the QAPI program did not contain data upon which complaint trends could be tracked and analyzed for emerging or continuing trends.</p>		<p>Interim HealthCare policy, "Complaints, dated 9/2/11". The documentation of the complaints was given to the surveyor on 10/13/15, and was found to be unacceptable to the surveyor. (Please see attachments). b. In the Interpretive Guidelines it states, "If resolution of the problem was not possible, the actions that were attempted and the outcomes should be documented by the HHA". c. The 2015 Agency Evaluation, and PAG meeting, per agency policy will take place on 4/5/16, for the 2015 year. Review of the policy, "Quality Improvement", states that the Administrator provides the following information at least annually to the governing body/owner: A summary of findings or trends related to ...patient/family complaints. Administration will ensure the QAPI program systematically monitors and evaluates the quality and appropriateness of patient care and provides documented improvement in patient care. The Administrator/designee provided education to all staff investigating complaints on the following: a. Regulation that the agency must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for the patient's property by anyone who is furnishing</p>	

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			<p>services on behalf of the agency, and must document both the existence of the complaint and the resolution of the complaint. b. Policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities form. c. Policy and procedure to complete the "Notice Regarding Payment responsibility" ensure patient/patient representative are provided written notice in advance, of the disciplines that will furnish care and the frequency of visits proposed to be furnished. If the frequency is not completed during admission (i.e. while waiting for Medicaid Prior Authorization (PA), a new form will be completed upon receipt of PA. d. Policy and procedure for reporting, resolving, and documenting complaints. e. Policy and procedure for obtaining patient/responsible party signature on the Homecare Admission Consent form to document that the Statement of Patient Rights and Responsibilities form is given to the patient and reviewed with the patient during the admission visit. f. Review of contents of Admission Packet, including "Your Rights and Responsibilities as a Health Care Client" with all clinical staff. g. Educate employees responsible for QAPI as to process for quarterly review and use of complaints in quality</p>	

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			<p>improvement activities.</p> <p>Monitoring: 1.The Administrator/designee will review 100% of new patient admission records each week during the corrective period to ensure that there is documentation of receipt of the Statement of Patient Rights and Responsibilities form and Notice Regarding Payment responsibility form is completed correctly. Monitoring will continue through the Quarterly clinical record review process. 2. The Administrator/designee will ensure that the policy/process in place to receive, investigate and resolve complaints, including documentation using the Patient/Client Complaint Form and Patient/Client Complaint Log, 3. The administrator/designee will meet with the QA staff and Nursing Supervisor to review quarterly QAPI and assure plans are in place for quality improvement.</p> <p>•The Administrator is responsible to ensure that each quarter the Clinical Record Review Committee meets in accordance with policies and completes the quarterly clinical chart audits. Audit results will be recorded in writing and forwarded to the QAPI committee for review. •The Clinical Supervisor/ QA Nurse will be responsible to oversee the chart audits during the Clinical Record Review Committee held quarterly and to spot check the medical records that were</p>	

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N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.  Based on record review and interview, the agency failed to maintain all	N 0462	reviewed. •The Annual Agency Review is presented to the PAG annually in April of the following year to allow for a complete assessment of the previous year. The 2015 Annual Agency Review will occur in 4/2016 where the 2015 Complaint summary will be presented to the PAG. •The Administrator/designee will be responsible to complete all in-services for all professional staff. The in-service will educate the staff as to the findings from the survey. 7 .Review of Action Plan specifics as a result of trends noted 5.All action plan results will be reviewed for the next quarter and the findings will be compiled and presented to the QAPI committee for review and approval that the issues are resolved. *The agency is requesting clarification of the above to improve our processes.  Each employee who will have direct patient contact shall have a physical examination by a	01/06/2016	

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	<p>personnel records in current condition to include a physical examination report attesting direct care providers were free of communicable disease, performed and signed by a physician or nurse practitioner, for 1 of 6 personnel files reviewed of direct care providers (employee K).</p> <p>The findings included:</p> <p>1. Policy "Interim HealthCare Health Screening Policy", was reviewed and stated, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact The exam will be sufficient in scope to prevent the spread of infectious and communicable diseases to patients."</p> <p>2. The personnel file of employee K was reviewed and evidenced the HHA was hired on 5-1-13 with first date of patient contact 5-4-13. A physical examination in the file, dated 2-26-14, was signed by a physician's assistant.</p> <p>3. On 11-23-15 at 3:30, the administrator</p>		<p>physician or nurse practitioner not more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients 1.On page 14 of 57, the surveyor stated that, "4. The personnel file of employee K was reviewed and evidenced the HHA was hired on 5/1/2013, with first date of contact 5-4-13. A physical examination in the file, dated 2-26-14, was signed by a physician's assistant." This statement is inaccurate. Employee K has a physical in her file dated 3/15/13, signed by an MD. 2.On page 14 of 57, #5, states that "Personnel file F, home health aide, date of hire 9-12-12, with direct patient contact 11-12-12, was reviewed and evidenced a TB skin test report with date of administration of 6-4-14, results 0 mm. The report failed to evidence the times administered and read". To improve performance and bring the agency into compliance with this Standard, the agency will take the following action: The Administrator/designee will complete a focused review on all personnel health records to assure time/date/signatures and completion are documented on all tuberculosis forms. Education:</p> <p>1. The Office nursing staff will be</p>				

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	indicated employee K had provided direct patient care as an agency employee and the physical examination was signed by a physician's assistant only.		re-educated on: a. Policy "Interim Health Care Health Screening Policy", revised 9-2009, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact. The exam will be sufficient in scope to prevent the spread of infectious and communicable diseases to patients." NOTE: Employee K has a Health Screening in the employee file dated 3/26/13. The physical cited by the surveyor does not belong to Employee K. b. The policy and procedure for Interim Health Care Health Screening Policy revised 9-2009 and the "Core Curriculum on Tuberculosis" that is stated as reference in our policy, was reviewed with all in- office nurse staff responsible for administering TB tests: "The tuberculin skin test should be read by a designated, trained health care worker 48-72 hours after the tuberculin skin test is placed. If the tuberculin skin test was not read between 48-72 hours, ideally, another tuberculin skin test should be placed as soon as possible and read within 48-72 hours. Monitoring: 1. Administrator/designee will conduct a focused review audit of		

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N 0464  Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis;		all employee health files to ensure that health files are current, timed, and dated appropriately. Monitoring will continue through the Quarterly clinical record review process. 2. The Administrator/designee will review all new employee documentation to assure compliance prior to allowing the employee to perform patient care until the end of the corrective period. Monitoring will continue through the Quarterly clinical record review process.		

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	<p>(ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on record review and interview, the agency failed to ensure personnel files of direct care providers contained either a valid negative one-step TB skin test upon hire, and a valid negative TB skin test within prior 12 months; or a valid two-step TB skin test upon hire, including documentation of the date and time of administration, and the date and time of reading/interpretation, for 1 of 6</p>	N 0464	<p>The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (f) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless</p>	12/28/2015

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	<p>non-positive TB skin test responder direct care provider personnel files reviewed (employee F).</p> <p>The findings included:</p> <p>1. Policy, "Interim HealthCare Addendum to TB policy per State Regulations", was reviewed and stated "The home health agency shall ensure that all employees, staff members, persons providing care of behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: ... After baseline testing, tuberculosis screening must: (A) Be completed annually; and (B) Include, at a minimum, a tuberculin skin test using the Mantoux method."</p> <p>1. " Guidelines for Preventing the Transmission of <i>Mycobacterium tuberculosis</i> in Health -Care Settings " , Volume 54, Page 46, Recommendations and Reports-17, 2005, was reviewed and stated " The tuberculin skin test should be read by a designated, trained health care worker 48-72 hours after the tuberculin skin test is placed. If the tuberculin skin test was not read between 48-72 hours, ideally, another tuberculin skin test should be placed as soon as possible and read within 48-72 hours. "</p>		<p>the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>To improve performance and bring the agency into compliance with this Standard, the agency will take the following action:</p> <p>The Administrator/designee has completed a focused review on all personnel health records to assure time/date/ and signatures are on tuberculosis form has been completed correctly. (completed 12/28/15)</p> <p>Education:</p> <p>1. The Office nursing staff has been re-educated on:</p> <p>a. Policy "Interim HealthCare Health Screening Policy", revised 9-2009, "Each employee having direct contact with clients must have documentation of baseline Health Screening prior to providing care to clients ... a pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by State law not greater than 180 days before the date of direct patient contact The exam will be sufficient in scope to prevent the spread of infectious and communicable diseases to patients."</p>		

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	2. Personnel file F, home health aide, date of hire 9-12-12, with direct patient contact 11-12-12, evidenced a TB skin test report with date of administration of 6-4-14, date of reading 6-6-14, results 0 mm. The report failed to evidence the times administered and read.		NOTE: Employee K has a Health Screening in the employee file dated 3/26/13. The physical cited by the surveyor does not belong to Employee K. b. The polices and procedure for Interim Health Care Health Screening Policy revised 9-2009 and the "Core Curriculum on Tuberculosis" that is stated as reference in our policy, was reviewed with all in- office nurse staff responsible for administering TB tests: "The tuberculin skin test should be read by a designated, trained health care worker 48-72 hours after the tuberculin skin test is placed. If the tuberculin skin test was not read between 48-72 hours, ideally, another tuberculin skin test should be placed as soon as possible and read within 48-72 hours. Monitoring: 1. The Administrator/designee will conduct a focused review audit of all employee health files to ensure that health files are current, timed, and dated appropriately. Monitoring will continue through the Quarterly clinical record review process. 2. The Administrator/designee will review all new employee documentation to assure compliance prior to allowing the employee to perform patient care until the end of the corrective period. Monitoring will continue through the Quarterly clinical record review process	

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N 0472  Bldg. 00	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on record review and interview, the agency failed to ensure the quality assessment performance improvement (QAPI) program identified objective data to be collected and analyzed related to patient/family complaints that could have resulted in identification of trends and a basis for actions to improve the spectrum of care for 1 of 1 agency.</p> <p>The findings included:</p> <p>1. Policy "Complaints", last reviewed/revised 9-2-11, was reviewed and stated, "Interim HealthCare receives, investigates, and resolves complaints ... the Administrator/Manager communicates the finding of the complaint investigations to the governing body/owner ... the</p>	N 0472	<p>Sec. 2. (a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agencies performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Corrective Action: To create performance improvement that demonstrates agency compliance to this Condition, the following will occur: 1. Reformulate the annual agency evaluation by the</p>	01/06/2016

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NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF SE INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 W EADS PKWY LAWRENCEBURG, IN 47025		
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	<p>Administrator/Manager or designee maintains the complaint logs and records of individual complaints, the investigation, and status upon closing in the quality improvement files."</p> <p>2. Policy "Quality Improvement ", last reviewed/revised 8-27-04, was reviewed and stated, "The Administrator/Manager or designee provides the following information at least annually to the governing body/owner: A summary of findings or trends related to ... patient/family complaints."</p> <p>3. Review of the QAPI program failed to evidence any objective data collected and used to track/trend complaints to be used as a basis for actions to improve processes, policies, and staff across the spectrum of care offered by the agency.</p> <p>4. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated the QAPI program did not contain data upon which complaint trends could be tracked and analyzed for emerging or continuing trends and used a basis for actions to improve services across the spectrum of care offered by the agency.</p>		<p>Professional Advisory Group, to emphasize the analysis and development of quality improvement strategies to include complaint resolution/complaint summary.</p> <p>2. Include revised format in report to Governing Body at least yearly.</p> <p>Education: The Administrator/designee provided education to all staff investigating complaints on the following:</p> <p>a. Regulation that the agency must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for the patient's property by anyone who is furnishing services on behalf of the agency, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>b. Policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities form.</p> <p>c. Policy and procedure to complete the "Notice Regarding Payment responsibility" ensure patient/patient representative are provided written notice in advance, of the disciplines that will furnish care and the frequency of visits proposed to be furnished. If the frequency is not completed during admission (i.e.</p>		

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			<p>while waiting for Medicaid Prior Authorization (PA), a new form will be completed upon receipt of PA.</p> <p>c. Policy and procedure for reporting, resolving, and documenting complaints.</p> <p>d. Policy and procedure for obtaining patient/responsible party signature on the Home care Admission Consent form to document that the Statement of Patient Rights and Responsibilities form was given to the patient and reviewed with the patient during the admission visit.</p> <p>e. Review contents of Admission Packet, including "Your Rights and Responsibilities as a Health Care Client" with all clinical staff.</p> <p>f. Educate employees responsible for QAPI as to process for quarterly review and use of complaints in quality improvement activities.</p> <p>Monitoring:</p> <p>1. The Administrator/designee will review 100% of new patient admission records each week during the corrective period to ensure that there is documentation of receipt of the Statement of Patient Rights and Responsibilities form and Notice Regarding Payment responsibility form is completed correctly. Monitoring will continue through the Quarterly clinical record review process.</p> <p>2. The Administrator/designee will ensure that the policy/process in</p>	

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N 0484 Bldg. 00	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on record review and interview, the agency failed to ensure all home health aides reported a change in the patient's condition to the supervising nurse for 1 of 3 patients who received home health aide services only (Patient #1).</p> <p>The findings included:</p> <p>1. Agency policy "Coordination of Care/Services " , dated 8-25-06, stated, "Interim HealthCare maintains regular communication with the patient/client and with others providing patient/client</p>	N 0484	<p>place to receive, investigate and resolve complaints, including documentation using the Patient/Client Complaint Form and Patient/Client Complaint Log, 3. The administrator will meet with the QA staff and Nursing Supervisor to review quarterly QAPI and assure plans are in place for quality improvement.</p> <p>This tag is not cited on our state survey. State tags go from N472 to N486. RESPONSE: N484; There is no plan of correction identified In review of the State SOD report, N484 is not a cited deficiency for the agency. This was documented in the POC submitted on 12-28-15. To improve performance and bring the agency into compliance to this Standard, the following has taken place: 1. The Administrator conducted an in-service on January 4, 2016 to all field staff who conduct comprehensive assessments regarding the use of the</p>	12/28/2015	

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	<p>services. Actions and goals of Interim HealthCare Services are complimentary and reflect cooperative care planning ... the director establishes processes to document coordination of care/services in the patient/client. "</p> <p>2. Review of patient #1's clinical record evidenced a start of care date of 9-11-12, The clinical record contained a physician's plan of care for the certification period 4-29 to 6-27-15 with order for home health aide services only up to 4 hours each day, 5 days a week for 9 weeks. A comprehensive assessment dated 4-24-15, was reviewed and evidenced patient's integumentary system was "within normal limits."</p> <p>3. Patient #1 indicated not being able to recall the date the ingrown toenail removal procedure was performed, but indicated it was in May or early June 2015. The patient stated the toenail bed healed without complication, and the HHA assigned had seen the toe and the bandage after the procedure was performed (dressing on approximately 1 week).</p> <p>4. A comprehensive assessment dated 6-23-15, was reviewed and evidenced a narrative comment by the registered nurse, "infected toe nail - removed now</p>		<p>Recertification of Care Checklist. This is a new tool created by the Administrator to ensure care coordination between disciplines, services provided, and any changes that have occurred since the last comprehensive assessment was addressed and documented in the patient file. All field staff were reeducated and given acopy of the Care Coordination Policy and the new Recertification of Care Checklist.</p> <p>2. The Administrator reeducated all Home Health Aides via amailing dated January 4, 2016. Themailing instructed all Home Health Aides in maintaining communication with the RN, including reporting all changes in client condition to the RN supervisor or to the supervising RN in the office. Educational materials were also posted to the employee corporate website on January 4, 2016.</p> <p>Monitoring: Administrator or designee will perform a focused review of 10 charts per week for evidence of comprehensive assessment to include skin assessment, history of physician visits, changes to the Plan of Care, and care coordination between all disciplines until the end of the corrective period and then 10% or at least 5 records will be reviewed quarterly to maintain compliance of 100%. Client #1 was an unskilled client who received monthly supervisory nursing visits. The client had an ingrown</p>		

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N 0486  Bldg. 00	<p>healed." There was no further documentation of the site of the procedure to include the appearance of the toenail bed or the size and color of the toenail bed.</p> <p>5. Home health aide (HHA) visit notes were reviewed for the certification period and failed to evidence any documentation of the patient having a toenail removal procedure, notification to the supervising nurse or the agency nursing supervisor, or any description of a dressing, the condition of the affected area during bathing. The HHA failed to coordinate services with the supervising registered nurse.</p> <p>6. On 10-13-15 at 2:30 PM, the administrator confirmed the above findings and indicated the HHAs of the agency are trained to report any change in the patients condition, to include a procedure to remove a toenail and the HHA should have notified and documented the observation to the supervising nurse when the event occurred.</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the</p>		<p>toenail and contracted toe. The aide failed to inform the supervisor of this information and that he had a toe procedure. Bandage was removed and the toe was healed prior to the 6-23-15 nursing assessment visit. During the visit, the nurse asked client #1 about any recent physician visits and the rationale. Client #1 informed the nurse that he had an ingrown toenail and toe procedure but could not recall the date. Nurse documented that the toe was healed which indicates "a within normal limit" integumentary system.</p>		

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	<p>patient.</p> <p>Based on record review, observation, and interview, the agency failed to ensure agency personnel maintained timely liaison with another agency providing services to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care for 2 of 3 records reviewed of patients receiving services from another agency (Patients #2 and 6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Agency policy "Coordination of Care/Services " , dated 8-25-06, stated, "Interim HealthCare maintains regular communication with the patient/client and with others providing patient/client services. Actions and goals of Interim HealthCare Services are complimentary and reflect cooperative care planning ... the director establishes processes to document coordination of care/services in the patient/client. "</li> <li>2. The clinical record of patient #2 was reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical</li> </ol>	N 0486	<p>The home health agency shall coordinate its services with other health or social service providers serving the patient Corrective Action: To create performance improvement that demonstrates agency compliance to this Condition, the following changes to agency processes will be made: Education: 1. The Administrator/designee will complete an in-service with the clinical staff to review the process for ensuring that the appropriate documentation is included in the clinical record when Interim Health Care and another cooperating agency is providing services to the patient. During the admission visit, the admitting discipline will document information regarding any other health provider that is providing services to the patient. The information will include the name of the provider and the services being provided. 2. The Administrator/designee will re-educate the Case Managers regarding their responsibilities if another agency is also providing care/services to the patient. The re-education will include the following: •The Case Manager will review the Care Plan and communicate with the other agency when any changes have been made, any issues with personnel. •Reporting any personnel issues to their Clinical Supervisors. Monitoring: •The</p>	01/06/2016

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	<p>record contained a plan of care for the certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to 8-19-15, was reviewed and evidenced an order for HHA services.</p> <p>b. Review of HHA visit notes during the certification period evidenced the HHAs transported the patient to a rehabilitation facility for physical and occupational therapy on the following dates:</p> <p>6-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-16-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-17-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-22-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>7-23-15 accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services</p> <p>8-17-15 accompanied patient and assisted patient to use public transportation to attend physical and</p>		<p>Administrator/designee responsible for auditing 100% the admission paperwork to screen the documentation for this information. If identified this information will be documented in the patient record for future reference. •The Administrator will perform a focused review of client records to monitor:</p> <p>a. An agreement is in place between the agencies, if applicable</p> <p>b. Current and signed Plan of Care indicating what and by whom other services are being provided to the patient</p> <p>c. Evidence in the documentation of care coordination and communication between agencies Issues noted will be incorporated into the quarterly QAPI reporting process</p>		

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	<p>occupational therapy services</p> <p>c. The plan of care, communication notes, case conference, supervisory visit notes were reviewed and failed to evidence coordination of care with the rehabilitation facility that provided physical and occupational therapy to the patient.</p> <p>3. During a home observation of a home health aide on 11-20-15 at 7:00 AM, patient #6 indicated because of the advanced state of multiple sclerosis, caregivers came in at night to provide care. The plan of care, case communication notes, and case conference notes were reviewed and failed to evidence coordination of care between the 2 providers.</p> <p>4. On 11-23-15 at 3:00 PM, the nursing supervisor indicated the clinical record communication notes, plan of care, and case conference notes failed to evidence coordination of care between the agency and a separately licensed agency providing care for patients #2 and #6. No further documentation was provided prior to exit.</p>			

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N 0504  Bldg. 00	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on record review and interview, the agency failed to ensure patient/patient representative were provided written notice in advance of the disciplines that would furnish care and the frequency of visits proposed to be furnished for 1 of 12 records reviewed (Patient #10).</p> <p>The findings included:</p> <p>1. Review of agency document, in the start of care packet provided to patients upon admission, "Your Rights and Responsibilities as a Health Care Client", copyright 2010, stated, "The client has the right to be informed in advance about the care to be furnished. The agency will inform the client in writing in advance of the disciplines that will furnish care and the frequency of proposed visits to be furnished. "</p>	N 0504	<p>The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient has the right to the following: Be informed about the care to be furnished and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Corrective Action: To create performance improvement that demonstrates agency compliance to this Condition, the following will occur: Education: The Administrator/designee will provide education to all professional staff responsible for doing admissions to home care regarding:</p>	01/06/2016

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	<p>2. The clinical record of patient #10, start of care 12-23-14, was reviewed and evidenced a form " Homecare Admission Consent Form " and a " Notice Regarding Payment Responsibility " , both signed by the patient on 7-30-14. A form " Financial Responsibility Agreement " was signed by the patient on 8-10-14. The consent forms failed to evidence the patient had been provided written notice, in advance of services furnished, of the disciplines and frequency of visits to be furnished. The plan of care was reviewed and evidenced the patient ' s plan of care order was for skilled nursing services, up to 7 hours per day, 7 days each week.</p> <p>3. On 11-23-15 at 3:00 PM, the nursing supervisor was unable to locate documentation the patient had been notified in writing of the disciplines that would furnish care and the frequency of proposed visits to be furnished.</p>		<p>a. Regulation that the patient has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.</p> <p>b. Regulation that the agency must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>c. Regulation that the agency must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>d. Policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities form and the Notice Regarding Payment Responsibility form, and the Financial Responsibility form including information on care to be furnished, disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>e. Policy and procedure for advising patients in advance of any change in the plan of care before the change is made.</p> <p>Monitoring: a. The Administrator/designee will review 100% of all new admission paperwork until the end of the corrective period for focused review of evidence providing all patients admitted to the agency with the Consent Form, Statement of Patient Rights and Responsibilities form and the Notice Regarding Payment</p>		

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N 0514 Bldg. 00	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on record review and interview, the agency failed to ensure the agency conducted a thorough investigation, which met their own policy, of patients' complaints for 3 complaints in the 2015 complaint log (Patients #2, 13, and 14).</p> <p>The findings included:</p> <p>1. Review of policy "Complaints", last reviewed/revised 9-2-11, stated, "Interim HealthCare receives, investigates, and resolves complaints ... the process of</p>	N 0514	<p>Responsibility form, including information on care to be furnished, disciplines that will furnish care, and the frequency of visits proposed to be furnished. Monitoring will continue through the Quarterly clinical record review process.</p> <p>c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. *All complaints cited in the survey, were both placed in the complaint</p>	01/06/2016

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	<p>receiving, investigating, and responding to complaints is in accordance with any applicable law, regulation, or contract requirement ... Definitions ... complaint: any expression of concern or dissatisfaction, or a protest regarding a circumstance ... resolved: the investigation of the complaint is completed and the Plan of Action is initiated ... Procedure: The Administrator/Manger or designee advises in-office and field employees to forward complaints to the Administrator/Manager or designee for follow-up ... the Administrator/Manager or designee establishes the circumstances surrounding the complaint ... determines if any immediate action is needed, and if so, takes the action and documents such ... complaints are deemed closed upon the signature of the Administrator/Manager or designee ... the Administrator/Manager communicates the finding of the complaint investigations to the governing body/owner ... the Administrator/Manager or designee maintains the complaint logs and records of individual complaints, the investigation, and status upon closing in the quality improvement files."</p> <p>2. Review of policy "Quality Improvement " , last reviewed/revised</p>		<p>log and investigated, however they were not acceptable to the surveyor. Corrective Action: To create performance improvement that demonstrates agency compliance to this Condition, the following will occur: 1. Reformulate the annual agency evaluation by the Professional Advisory Group, to emphasize the analysis and development of quality improvement strategies to include complaint resolution. 2. Include revised format in report to Governing Body at least yearly. Education: The Administrator/designee will provide education to all in-office staff investigating complaints on the following: a. Regulation that the agency must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for the patient's property by anyone who is furnishing services on behalf of the agency, and must document both the existence of the complaint and the resolution of the complaint. b. Policy and procedure for providing all patients admitted to the agency with the Statement of Patient Rights and Responsibilities form. c. Policy and procedure to complete the "Notice Regarding Payment responsibility" ensure patient/patient representative are provided written notice in advance, of the disciplines that</p>	

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NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF SE INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 500 W EADS PKWY LAWRENCEBURG, IN 47025			
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	<p>8-27-04, stated, "The Administrator/Manager or designee provides the following information at least annually to the governing body/owner: A summary of findings or trends related to ... patient/family complaints."</p> <p>3. The agency 2015 complaint log was reviewed and contained the following complaints:</p> <p>a. complaint dated 7-25-15, from spouse of patient #2, alleged billing irregularities and HHA, employee G, was not providing services according to the plan of care for the HHA services. The spouse alleged employee G transported the patient to physical and occupational therapy services at a health care facility, then went outside to smoke, and had to be located by the facility staff. The agency investigation addressed the billing irregularities only; the agency documentation failed to evidence an investigation of the allegation HHA, employee G, had not been available to provide hands on care for the patient during therapy sessions.</p> <p>b. complaint dated 8-8-15, from parent of patient #13, on agency complaint form, with attached email from person initially taking the complaint with several allegations, failed to identify the employee HHAs whom one of the</p>		<p>will furnish care and the frequency of visits proposed to be furnished. If the frequency is not completed during admission (i.e. while waiting for Medicaid Prior Authorization (PA), a new form will be completed upon receipt of PA. c. Policy and procedure for reporting, resolving, and documenting complaints. d. Policy and procedure for obtaining patient/responsible party signature on the Home care Admission Consent form to document that the Statement of Patient Rights and Responsibilities form was given to the patient and reviewed with the patient during the admission visit. e. Review contents of Admission Packet, including "Your Rights and Responsibilities as a Health Care Client" with all clinical staff. f. Educate employees responsible for QAPI as to process for quarterly review and use of complaints in quality improvement activities. Monitoring The Administrator/designee will review 100% of new patient admission records until the end of the correction period to ensure that there is documentation of receipt of the Statement of Patient Rights and Responsibilities form and Notice Regarding Payment responsibility form is completed correctly. Monitoring will continue through the Quarterly clinical record review process. 3. The Administrator/designee will ensure that the policy/process in</p>				

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	<p>allegations was made against " Mom stated ... she is tired of HHA ' s not knowing what they are supposed to do " The complaint investigation documentation failed to establish the circumstances surrounding the complaint and/or whether the allegations were credible and the investigation did not address all the allegations made in the complaint. The complaint data failed to evidence how the data obtained could be used by the agency for quality improvement activities.</p> <p>c. complaint dated 8-11-15, from patient #14, included allegations an agency HHA had stolen the patient ' s medication, clothes, and towels; HHA brought a laptop to patient ' s home and used it instead of providing care, patient asked HHA to go to patient ' s mother ' s home and pick up and cash a check every week, and HHA brought back \$100 of \$200 on the check; patient sent HHA to store to buy items for patient and items on the receipt were not brought back to the patient; HHA had fallen asleep on duty. The agency investigation documentation evidenced " this was not the first complaint like this " and the HHA had " brought her kids with her to work " in patient ' s home. The complaint was signed as resolved on 8-13 -15, and discipline of written warning was the plan of action identified. There</p>		<p>place to receive, investigate and resolve complaints, including documentation using the Patient/Client Complaint Form and Patient/Client Complaint Log, 4. The administrator will meet with QA staff and the Nursing Supervisor to review quarterly QAPI and assure plans are in place for quality improvement.</p>	

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	<p>were 2 discipline memos in employee I, HHA, identified in the complaint, personnel file. The first was a memorandum dated 8-11-15, indicating the agency would give the employee a written warning when able to contact employee by phone to come in to the agency. The second disciplinary memo, dated 8-13-15, indicated employee I had been terminated for no show, no call on 8-11-15. The complaint investigation failed to establish the circumstances surrounding the complaint and/or whether the allegations were credible and the investigation did not address all the allegations made in the complaint. The complaint data failed to evidence how the data obtained could be used by the agency for quality improvement activities.</p> <p>4. On 11-11-15, at 10:00 AM, the administrator/nursing supervisor, was interviewed and indicated the grievance investigations did not meet the agency policy and the investigations did not include data that could be tabulated and used by the agency to plan quality improvements activities. No further documentation was provided prior to exit.</p>			

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N 0520 Bldg. 00	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on record review and interview, the agency failed to ensure patients were accepted and continued on service for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs could be met adequately by the agency in the patient's place of residence for 3 of 12 clinical records reviewed (Patients #1, 2, and 12).</p> <p>The findings included:</p> <p>1. Review of policy "Plan of Care", last reviewed/revised 8-27-04, stated, "Interim HealthCare provides care/service in accordance with the Plan of Care ... and standards of practice. "</p> <p>2. Review of policy " Admission to Home Care " , dated 5-14-10, stated, " An individual is admitted to home care only if: a) the needed care/service can be provided by appropriately qualified</p>	N 0520	<p>Patients are accepted for treatment with the expectation that the patient's needs can be adequately met by the HHA in the patient's residence.</p> <p>Corrective Action: To improve performance and bring the agency into compliance to this Standard, the following will take place: Education: Education of all staff to policies and procedures: 1.Review of policy "Plan of Care", "Admission to Home Care " , "Missed Visits". 2.Administrator/designee reviewed interoffice process of communicating missed visits to appropriate staff so that appropriate and supporting documentation can be completed. 3.Medical orders can include specific range in visit frequency. 4.Ranges cannot include "0" as frequency PRN orders may be used with specified limits. 5.Alert physicians to all changes in visit frequency or changes in client's condition that indicate need to modify plan of care.</p>	01/06/2016

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	<p>employees in a timely manner and at the level of intensity indicated by the individual ' s identified needs ... the location where the individual will receive care is within the geographic service area defined by the Office. "</p> <p>3. The clinical record of patient #1 was reviewed and evidenced a start of care 9-11-12, and diagnoses Friedrich ' s Ataxia and scoliosis, Medicaid payor. Three (3) plans of care and certification periods were reviewed: 4-29 to 6-27-15, 6-28 to 8-26-15, and 8-27 to 10-25-15.</p> <p>a. The plan of care contained an order for the certification period 4-29- to 6-27-15, for home health services up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>During the certification period the week of 5-11 to 5-17-15 the patient received 4 visits and 16 hours of HHA care rather than the ordered 5 visits and up to 20 hours of HHA care. The clinical record lacked documentation of the reason of the missed visit, or notification to physician.</p>		<p>Maintain documentation in clinical records that physician was notified of changes, missed visits or any other instances of need to modify plan of care.</p> <p>6.Client assessments &amp; signed physician orders drive provision of appropriate care and services. Assessment of patients' medical, nursing, and social needs and evaluation of the agency's ability to meet those needs adequately.</p> <p>7.Documentation clearly evidences that all care &amp; services were provided as ordered and any reasons of variation.</p> <p>8.Identified problems and clear documentation of interventions, additional client/ family needs and how the needs were met or reasons why needs were unable to be met.</p> <p>9.Case conferencing and collaboration.</p> <p>10.When a plan of care cannot be met, Administrator/designee will be consulted along with physician and client to offer/facilitate change in provider/change in POC that will allow client needs to be met. If the client does not wish to change agencies, the agency will work with client, physician, and State to develop a plan for how the patient ' s needs will met in the absence of agency services.</p> <p>Monitoring: The Administrator/designee will review 10 charts per week through the end of the corrective period for evidence of patient's</p>				

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	<p>On 6-23-15, the comprehensive assessment by registered nurse, Employee F, noted "infected toenail - removed now healed." Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care.</p> <p>b. During the certification period 6-28 to 8-26-15, the plan of care order was for home health services (HHA) up to 4 hours each day, 5 days each week, for 9 weeks "to assist/perform personal care/ADLs/IADLs/keep patient's environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient's condition." Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care. Review of HHA visit notes failed to evidence HHA visits during the PM from 7-17-15 daily throughout the certification period until 8-26-15, a total of 41 dates in which no HHA PM services were provided. No weekend hours of HHA service were provided. During this certification</p>		<p>needs can be adequately met by the HHA in patient's residence and for physician orders obtained for all interventions provided. Monitoring will continue through the Quarterly clinical record review process.</p>	

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	<p>period, the patient had an ingrown toenail removal procedure, date unknown. The HHA visit notes were reviewed and failed to evidence any documentation of the presence or absence of a dressing, the appearance of the foot when able to bathe or shower the patient, or notification to the supervising nurse of a change in the patient ' s condition related to having had a surgical procedure. A follow-up comprehensive assessment dated 6-23-15 evidenced " infected toenail removed now healed. " The nursing notes, communication notes, and physician orders were reviewed and failed to evidence the attending physician had been contacted regarding the change in condition and consulted for further orders.</p> <p>c. During the certification period 8-27 to 10-25-15, the plan of care order was for home health services up to 6 hours each day, 7 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " The HHA visit notes were reviewed and</p>			

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	<p>failed to evidence HHA had provided services of up to 4 hours during the day, and up to 2 hours in the evening. The HHA visit notes were for 5 days each weekday only, 5 hours during the day. No PM hours were provided between 8-27-15 and 9-15-15, a total of 20 dates in the certification period with HHA visits not provided as ordered on the plan of care. No weekend hours of HHA service were provided. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient ' s needs were met in the absence of agency services. The patient was discharged 9-15-15, per patient request, to transfer to another agency.</p> <p>4. The clinical record of patient #2 was reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical record contained a plan of care for the</p>			

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	<p>certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to 8-19-15, contained an order for HHA services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient's condition." b. Review of the HHA visit notes failed to evidence HHA had provided services on 7-2,7-3, 7-13, 7-20, 7-21, 8-3 to 8-7, and 8-10 to 8-14-15. HHA visit on 7-24-15 was for 6.5 hours, not 8 hours as ordered. Review of the communication notes and physician orders failed to evidence any documentation of the reason for the missed visits, short visit, notification to the attending physician of the agency failure to provide services as ordered, or how the patient ' s care needs were met in the absence of agency services. The date of discharge was 9-8-15, per patient request, to transfer to another agency.</p> <p>5. The clinical record of patient #12 was reviewed, and evidenced a start of care</p>			

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	<p>8-4-15, diagnoses cerebral palsy, epilepsy, and intellectual impairment, Medicaid payor. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. " The first HHA visit note was dated 10-14-15, more than 2 months after the start of care date. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient ' s needs were met in the absence of agency services.</p> <p>6. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency has experienced a shortage of qualified staff over the last year, especially nurses and home health aides, and has had been unable to meet</p>			

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N 0522 Bldg. 00	<p>all the required visits according to the plan of care, especially in rural areas far from the Lawrenceburg agency.</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:</p> <p>Based on record review and interview, the agency failed to ensure services were provided as ordered by the physician on the plan of care for 3 of 12 records reviewed (Patients # 1, 2, and 12) and failed to include an order of frequency of services of 1 or greater for 1 of 12 records reviewed (Patient #4).</p> <p>The findings included:</p> <p>1. Review of policy "Plan of Care", last reviewed/revised 8-27-04, stated, "Interim HealthCare provides care/service in accordance with the Plan of Care ... and standards of practice. "</p>	N 0522	<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: *Patient #12 was admitted to the agency on 8/4/15 for a PA assessment. The PA assessment was sent to MDWise Hoosier Care Connect and authorization was returned on 10/7/15. Care started on 10/14/15 due to delayed PA authorization. The nurse completed two Communication/Care Coordination notes given to the surveyor on 9/3/15 and 10/2/15, where the physician was notified that the client care had not started due to the PA pending(See Attached). The agency is requesting clarification since we are not finding an error.</p>	01/06/2016

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	<p>2. Review of policy "Variances from the Plan of Care/Service Plan " , last reviewed/revised 8-27-04, stated, "Interim HealthCare follows the plan of care/service plan as written ... Interim HealthCare takes precautions to avoid a missed visit, shift, or reduced hours ... patients/clients receive care/services that they require at the frequency and duration ordered ... If the office is unable to fill the visit/shift/hour requirement of a patient/client, then the DHCS or designee: contacts the patient/client/caregiver to reschedule the visit/shift to comply with the health care practitioner ' s orders ... If rescheduling is not an option, the designated employee identifies the patients/client ' s on-going needs during this unfilled visit/shift or reduced hours ... the designated employee identifies alternative measures/means to ensure the patient ' s/client ' s needs are met (e.g. family, friends, neighbors, group contractors able to fulfill the need) ... if alternative means cannot be identified and the visit/shift/hours are not filled but the missed care/services do not put the patient/client at risk, the DHCS or</p>		<p>Corrective Action: 1.N522, p. 24 of 47, the surveyor states that patient #1: "During the certification period the week of 5-11 to 5-17-15 the patient received 4 visits and 16 hours of HHA care rather than the ordered 5 visits and up to 20 hours of HHA care. The clinical record lacked documentation of the reason of the missed visit, or notification to physician". 2.The above is incorrect as the surveyor was given 5 visit notes from 5/11/15 to 5/15/15, equaling 5 visits and 20 hours of care this week. (See Attached). 3.N522, p. 26-27 of 47, patient #2, the surveyor stated "review of the HHA visit notes failed to evidence HHA had provided services on 7/3/15, 7/21/15, 8/3/15-8/7/15 and 8/10/15-8/14/15), and (failed to evidence any documentation of the reason for the missed visits". The missed visit notes for the above dates were given to the surveyor (See attached). 4.N522, p. 27 of 47, patient #12 with a start of care 8/4/15, the surveyor stated "The first HHA visit note was dated 10/14/15 more than two months after the start of care date. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient's needs were met in the absence of agency services".</p>	

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	designee notifies all parties including the ordering health care practitioner (e.g. physician) ... and documents such ... If alternative means cannot be identified and the patient/client will be put at risk by not filling the visit/shift/hour requirement, then the DHCS or designee notifies all parties including any ordering health care practitioner ... that the patient/client must be temporarily transferred to another care/delivery location (e.g. ER, hospital, adult day care, another provider) for care services ... the DHCS or designee tracks the frequency and reasons for missed visit/shift or reduced hour variances and periodically analyzes trends ... if a pattern of missed visits/shifts or reduced hours develops, the DHCS assesses: staffing patterns and skill matching; recruiting/retention efforts; appropriateness of admission decisions (e.g. current staff unable to meet growing visit/shift needs); and geographic distribution of field employees versus patients/clients admitted ... If the DHCS detects trends of care/service variances, he/she ... develops and implements a corrective plan of action. "		This issue is secondary to the time that Medicaid PA authorization was received. This patient had a comprehensive assessment on 10/2/2015, as a re certification. The agency is confused regarding how many admissions we are required to do to request a PA. We must do an admission in order to procure a PA and the above would require another admission on 10/14/2015. The agency is requesting clarification regarding this issue. To improve performance and bring the agency into compliance to this Standard, the following will take place: Education: Education of all staff to policies and procedures: 1. Review of policy "Plan of Care", "Admission to Home Care ", "Missed Visits" 2. Administrator/designee reviewed interoffice process of communicating missed visits to appropriate staff so that appropriate and supporting documentation can be completed. 3. Medical orders can include specific range in visit frequency. Ranges cannot include "0" as frequency PRN orders may be used with specified limits 4. Alert physicians to all changes in visit frequency or changes in client's condition that indicate need to modify plan of care. Maintain documentation in clinical records that physician was notified of changes, missed visits or any				

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	<p>3. The clinical record of patient #1 was reviewed and evidenced a start of care 9-11-12, and diagnoses Friedrich ' s Ataxia and scoliosis, Medicaid payor. Three (3) plans of care and certification periods were reviewed: 4-29 to 6-27-15, 6-28 to 8-26-15, and 8-27 to 10-25-15.</p> <p>a. The plan of care contained an order for the certification period 4-29- to 6-27-15, for home health services up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " During the certification period the week of 5-11 to 5-17-15 the patient received 4 visits and 16 hours of HHA care rather than the ordered 5 visits and up to 20 hours of HHA care. The clinical record lacked documentation of the reason of the missed visit, or notification to physician. On 6-23-15, the comprehensive assessment by registered nurse, Employee F, noted " infected toenail - removed now healed. " Interim physician order dated 6-9-15, approved by prior</p>		<p>other instances of need to modify plan of care. 5. Client assessments &amp; signed physician orders drive provision of appropriate care and services. Assessment of patients' medical, nursing, and social needs and evaluation of the agency's ability to meet those needs adequately 6. Documentation clearly evidences that all care &amp; services were provided as ordered and any reasons of variation 7. Identified problems and clear documentation of interventions, additional client/ family needs and how the needs were met or reasons why needs were unable to be met. 8. Case conferencing and collaboration 9. When a plan of care cannot be met, Administrator/designee will be consulted along with physician and client to offer/facilitate change in provider/change in POC that will allow client needs to be met. If the client does not wish to change agencies, the agency will work with client, physician, and State to develop a plan for how the patient ' s needs will met in the absence of agency services. Monitoring: Administrator or designee will review 20 charts per week until the end of the corrective period for evidence of patient's needs can be adequately met by the HHA in patient's residence and physician orders obtained for all interventions provided. Monitoring will continue through the</p>	

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	<p>authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care.</p> <p>b. During the certification period 6-28 to 8-26-15, the plan of care order was for home health services (HHA) up to 4 hours each day, 5 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " Interim physician order dated 6-9-15, approved by prior authorization per Medicaid on 7-16-15, increased HHA hours to add 2 hours in the evening to assist with PM care. Review of HHA visit notes failed to evidence HHA visits during the PM from 7-17-15 daily throughout the certification period until 8-26-15, a total of 41 dates in which no HHA PM services were provided. No weekend hours of HHA service were provided. During this certification period, the patient had an ingrown toenail removal procedure, date unknown. The HHA visit notes were reviewed and failed to evidence any documentation of</p>		<p>Quarterly clinical record review. RESPONSE: For G158/N522; To clarify, a missed visit form does not excuse a provider from meeting the physician ordered planof care if unable to staff visits. Please ensure awareness of this. The agency is aware that a missed visit form does not excuse provider from meeting the physician's ordered plan of care for each patient. An agency plan is in place to analyze trends. If a detection of trends in care/services variances develops, the Administrator/Nursing supervisor will implement a corrective plan of action up to and including transferring the patient to another agency or facility.</p>				

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	<p>the presence or absence of a dressing, the appearance of the foot when able to bathe or shower the patient, or notification to the supervising nurse of a change in the patient ' s condition related to having had a surgical procedure. The HHA did not follow the plan of care order to notify the nurse of any change in the patient ' s condition. A follow-up comprehensive assessment dated 6-23-15 evidenced " infected toenail removed now healed. "</p> <p>The nursing notes, communication notes, and physician orders were reviewed and failed to evidence the attending physician had been contacted regarding the change in condition and consulted for further orders.</p> <p>c. During the certification period 8-27 to 10-25-15, the plan of care order was for home health services up to 6 hours each day, 7 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. " The HHA visit notes were reviewed and failed to evidence HHA had provided services of up to 4 hours during the day,</p>			

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	<p>and up to 2 hours in the evening. The HHA visit notes were for 5 days each weekday only, 5 hours during the day. No PM hours were provided between 8-27-15 and 9-15-15, a total of 20 dates in the certification period with HHA visits not provided as ordered on the plan of care. No weekend hours of HHA service were provided. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient 's needs were met in the absence of agency services. The patient was discharged 9-15-15, per patient request, to transfer to another agency.</p> <p>4. The clinical record of patient #2 was reviewed, and evidenced a start of care 4-22-15, diagnoses congestive heart failure, chronic airway obstruction, traumatic brain injury, and history of thrombosis, Medicaid payor. The clinical record contained a plan of care for the certification period 6-21 to 8-19-15.</p> <p>a. The plan of care 6-21 to 8-19-</p>			

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	<p>15, contained an order for HHA services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient's environment clean and odor free. HHA is to call RN for any changes or concerns in patient's condition. " b. Review of the HHA visit notes failed to evidence HHA had provided services on 7-2, 7-3, 7-13, 7-20, 7-21, 8-3 to 8-7, and 8-10 to 8-14-15. HHA visit on 7-24-15 was for 6.5 hours, not 8 hours as ordered. Review of the communication notes and physician orders failed to evidence any documentation of the reason for the missed visits, short visit, notification to the attending physician of the agency failure to provide services as ordered, or how the patient ' s care needs were met in the absence of agency services. The date of discharge was 9-8-15, per patient request, to transfer to another agency.</p> <p>5. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15, diagnoses cerebral palsy, epilepsy, and intellectual impairment,</p>			

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	<p>Medicaid payor. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. " The first HHA visit note was dated 10-14-15, more than 2 months after the start of care date. The communication notes and physician orders were reviewed and failed to evidence the attending physician had been notified of the delay in starting service and failed to evidence documentation of how the patient ' s needs were met in the absence of agency services.</p> <p>6. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency has experienced a shortage of qualified staff over the last year, especially nurses and home health aides, and has had been unable to meet all the required visits according to the plan of care, especially in rural areas far</p>			

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N 0524  Bldg. 00	<p>from the Lawrenceburg agency. The administrator indicated the agency has made efforts to improve retention and increase recruitment, but was unable to provide an action plan.</p> <p>7. The clinical record of patient #4 was reviewed and evidenced a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide (HHA) services " 0W1, 2W8. " The HHA order failed to evidence a frequency of greater than zero (0) for the order regarding the first week of the certification period.</p> <p>8. On 11-23-15 at 4:30 PM, the administrator indicated not being aware the physician plan of care order did not include duration for the HHA services and included a frequency of " 0. "</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses.</p>						

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	<p>(C) Include the following:</p> <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> <p>Based on record review, interview, and observation, the agency failed to ensure the plan of care and certification periods on the plan of care were correct for 2 of 12 records reviewed (Patients # 10 and 12) ; failed to ensure the duties of disciplines providing services to the patient were specified for 2 out of 5 records reviewed of patients receiving home health aide services (Patients # 2 and 12); and failed to ensure all necessary durable medical equipment and supplies were included on the plan of care for 1 of 12 records reviewed (Patient #4), and failed to ensure plan of care orders for services included a duration for each discipline ordered and a frequency of greater than 0 for X of 12 records</p>	N 0524	N-0524 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (C) Cover all pertinent diagnoses. (D) Include the following: 1.Mental status. 2.Types of services and equipment required 3.Frequency and duration of visits 4.Prognosis 5.Rehabilitation 6.Functional Limitation 7.Activities permitted 8.Nutritional requirements 9.Medications and treatment 10.Any safety measure to protect against injury 11.Instructions for timely manner 12.Therapy modalities specifying length of treatment 13.Any other appropriate items N524 pg. 29 of 47, the surveyor stated "each	01/06/2016

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	<p>reviewed (Patient # X).</p> <p>The findings included:</p> <p>1. The clinical record of patient #10 was reviewed on 11-23-15, and evidenced a start of care date of 7-30-15, defined as the first billable visit, and contained a physician's plan of care for the certification period 9-23 to 11-21-15, with order for skilled nursing services up to 7 hours a day, 7 days each week, Medicaid payer. The clinical record evidenced a start of care comprehensive assessment dated 7-30-14. Review of visit notes evidenced the first billable visit, with care furnished, was on 8-11-14 by a registered nurse. The start of care should have been 8-11-14, and the certification periods should have been 8-11-14 to 10-9-14, 10-10- to 12-8-14, 12-9-14 to 2-6-15, 2-7 to 4-7-15, 4-8 to 6-6, 6-7 to 8-5, 8-6 to 10-4, and 10-5 to 12-3-15.</p> <p>2. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care established by a physician for the certification period 10-3 to 12-1-15 with order for HHA services 3 times each week. Review of visit notes evidenced the first billable visit, with care furnished, was on 10-14-15, by a</p>		<p>duty of the home health aide should be spelled out on the 485".</p> <p>The agency is requesting clarification because the duties are listed on the home health aide care plan. N524 pg. 29 of 47, patient #10 had a start of care on 7/30/15. The clinical record of patient #10, start of care date was 7/30/14, not 7/30/15. The patient was assessed for a Medicaid Prior Authorization on 7/30/2014. The agency typically uses the date of assessment for a Medicaid PA as the Start of Care date because in order to get a PA approved, the documentation to the State requires paperwork, including a signed 485 from the Physician. In order to achieve this requirement, the patient has to be admitted to the agency even though the actual PA won't occur until the State of Indiana Medicaid gives the agency authorization to provide the care. This includes an OASIS assessment if the patient is an adult and is going to be receiving skilled care. The admitting nurse does provide medication teaching and reconciliation which is considered to be a skill in the Medicare/Medicaid regulations. The OASIS is transmitted to the State. Once the authorization is received by the agency from Indiana Medicaid, the actual PA care can begin. It can take weeks to obtain this authorization, thus the delay in care. This process needs clarification from the State</p>		

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	<p>HHA, more than 2 months after the start of care date. A start of care comprehensive assessment was performed on 8-4-15. The start of care date should have been 10-14-15, and the certification period should have been 10-14 to 12-12-15.</p> <p>3. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for home health aide (HHA) services " 8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient ' s environment clean and odor free. HHA is to call RN for any changes or concerns in patient ' s condition. "</p> <p>a. Review of the HHA care plan, updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided; perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist</p>		<p>as there is no current process in place for a Medicaid agency to follow. The patient was hospitalized on 8/7/14 and returned home on 8/8/14. On 8/10/14 the nurse performed a Resumption of Care, with orders for a Medicaid Code 50 (up to 120 hours of care/30 days). To improve performance and bring the agency into compliance to this Standard, the following will take place: Corrective Action: Administrator/designee will provide 1:1 education to staff involved in the provision of care to patient #12 regarding activities permitted in completing the plan of care. Patient #10 has been discharged from the agency. Education: 1.The Administrator/designee will instruct all home health aide personnel in the requirement to follow the plan of care for tasks such as turning, re-positioning and range of motion exercises. 2.The Administrator/designee will instruct all registered nurse personnel who supervise home health aides to observe for implementation of the plan of care by the aide. Monitoring: Administrator or designee will perform a focused review 10 charts per week until the end of the corrective period for presence of home health aide documentation that matches the plan of care. Monitoring will continue through the Quarterly clinical record review process.</p>		

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	<p>with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client ' s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p> <p>b. Review of HHA visit notes during the certification period evidenced the HHAs performed duties on the following dates: 6-22-15 complete bed bath, perineal care, hair care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion. 6-23-15 partial bed bath, perineal care,</p>			

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	<p>prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>6-24-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>6-25-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion , cleaned kitchen, and washed dishes.</p> <p>6-26-15 partial bed bath, perineal care,</p>			

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	<p>prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, assisted with range of motion 6-29 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>6-30-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-1-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the</p>			

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	<p>patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-6-15 complete perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-7-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-8-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body,</p>			

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	<p>provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-9-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-10-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-14-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for</p>			

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	<p>reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-15-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-16-15 perineal care, hair care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-17-15 prepared meals, served meals, cleaned kitchen, washed dishes, dressed</p>			

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	<p>the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion. The HHA visit note failed to evidence perineal care had been provided.</p> <p>7-22-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-23-15 perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open</p>			

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	<p>areas, assisted the patient to use the urinal, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>7-24-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, cleaned patient ' s area, assisted with range of motion, and took patient outside for a picnic.</p> <p>7-27-15 partial bed bath, perineal care, shaved patient, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-28-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body,</p>			

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	<p>provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-29-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>7-30-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens, and assisted with range of motion.</p> <p>7-31-15 partial bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for</p>			

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	<p>reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, and assisted with range of motion.</p> <p>8-3 to 8-7-15 and 8-10 to 8-14-15 copies of HHA visit notes were requested but not provided.</p> <p>8-17-15 partial bed bath, perineal care, hair care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, cleaned client ' s area, made bed, turned and positioned patient, changed bed linens, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>8-18-15 complete bed bath, perineal care, prepared meals, served meals, cleaned kitchen, washed dishes, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, changed bed linens,</p>			

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	<p>made bed, and assisted with range of motion.</p> <p>8-19-15 complete bed bath, perineal care, prepared meals, served meals, dressed the patient ' s upper and lower body, provided oral hygiene, inspected skin for reddened or open areas, assisted the patient to use the urinal, assisted with transfers using a slide board, assisted patient with wheelchair, turned and positioned patient, accompanied patient and assisted patient to use public transportation to attend physical and occupational therapy services at a facility, and assisted with range of motion.</p> <p>c. None of the HHA notes evidenced how often, or at what times, the patient was turned while in bed. None of the HHA visit notes documented any care rendered while patient was receiving physical and occupational therapy outside the home.</p> <p>d. The plan of care goal for HHA services was " the client will have personal needs and ADLs met, meals prepared, remain safe in the home and live in a clean and odor free environment with the assist of the HHA throughout the certification period. "</p> <p>e. The agency failed to specify on the physician plan of care orders the type and frequency of personal care and ADLs the home health aides were to provide. The physician plan of care failed to</p>			

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	<p>evidence an order for HHAs to accompany/transport patient #2 to therapy appointments.</p> <p>3. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. "</p> <p>a. The HHA plan of care was reviewed and evidenced it was created on 8-4-15, and updated on 10-2-15. The duties delegated to the HHA were: " shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave as needed, nail care, hair care, skin care; observe for reddened or open areas, apply lotion, apply powder, keep skin clean and dry, assist with toilet commode, assist with ambulation-walker, wheelchair; assist with transfers, slide board, grab bars, gait belt, turn and position, range of motion lower extremities, vacuum client ' s area, dust client ' s area, clean client ' s bathroom, clean and straighten client ' s area, make client ' s bed, do client ' s laundry, change client ' s linen, clean client ' s kitchen, wash client ' s dishes,</p>			

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	<p>do not transport. " The HHA plan of care failed to specify active or passive range of motion.</p> <p>b. HHA visit note dated 10-14-15 was reviewed and evidenced the HHA performed the following: shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave with razor, nail care, hair care, skin inspected, lotion applied, powder applied, skin clean and dry, assisted with toilet commode, assisted with ambulation-walker, wheelchair, assisted with transfers, slide board, grab bars, range of motion, vacuumed client ' s area, dusted client ' s area, cleaned bathroom, cleaned and straightened client ' s area, made bed, did client ' s laundry, and changed client ' s linen.</p> <p>c. The plan of care goal for HHA services was " the patient ' s hygiene and personal care needs will be met this certification period with the assistance of the home health aide. The patient ' s home environment will be clean and odor free throughout the certification period. "</p> <p>d. The agency failed to specify on the physician plan of care orders the type and frequency of personal care and ADLs the home health aide was to provide.</p> <p>4. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor, indicated the agency customarily has</p>				

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	<p>written, and sent to the physician for signature, HHA duties of " personal care, ADLs and IADLs, keep patient ' s environment safe, clean, and odor free. "</p> <p>The administrator was unable to define an accepted definition of personal care, and confirmed the physician ' s plan of care HHA orders did not provide a specific order related to the patient ' s hygiene needs for patient #2 and 12.</p> <p>5. The clinical record of patient #4 was reviewed and evidenced:</p> <p>a. a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide and physical therapy. The plan of care medication orders evidenced "albuterol sulfate 2.5 mg/3mL, 1 vial nebu PRN 4 times a day inhalation for shortness of breath/wheeze." The durable medical equipment and supplies on the plan of care evidenced "None ".</p> <p>b. The clinical record contained a plan of care for the certification period 11 -5 to 1-3-16 with orders for home health aide (HHA) services " 0W1, 2W8. " The HHA order failed to evidence a frequency of greater than zero (0) for the order regarding the first week of the certification period, and failed to evidence a duration for the HHA order.</p>			

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N 0542 Bldg. 00	<p>c. On 11-23-15 at 4:30 PM, the administrator indicated not being aware the order on the physician plan of care did not include duration for the HHA services and included a frequency of " 0. "</p> <p>6. During a home observation of a physical therapist on 11-19-15 at 2:00 PM, a nebulizer and disposable examination gloves were observed in the home. The patient indicated using the nebulizer for " breathing treatments. " The registered nurse failed to update the plan of care to include the nebulizer and the examination gloves.</p> <p>7. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated not being aware the nebulizer was not listed as durable medical equipment, and examination gloves should be on each plan of care for universal precautions and infection control purposes.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where</p>			

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	<p>services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on record review, observation, and interview, the agency failed to ensure the registered nurse revised and updated the plans of care to include all durable medical equipment (Patient #4) and specific home health duties in relation to hygiene for 3 of 5 records reviewed receiving home health aide services (Patients # 2, 6, and 12).</p> <p>The findings included:</p> <p>1. The clinical record of patient #4 was reviewed and evidenced a physician plan of care with start of care date 11-5-15. The clinical record contained a plan of care for the certification period 11-5 to 1-3-16 with orders for home health aide and physical therapy. The plan of care medication orders evidenced " albuterol sulfate 2.5 mg/3mL, 1 vial nebu PRN 4 times a day inhalation for shortness of breath/wheeze." The durable medical equipment and supplies on the plan of care evidenced " None " .</p> <p>2. During a home observation of a physical therapist on 11-19-15 at 2:00</p>	N 0542	<p>N 542 410 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. To improve performance and bring the agency into compliance to this Standard, the following will take place: Corrective Action: This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the agency failed to ensure the registered nurse revised and updated the plans of care to include all durable medical equipment (Patient #4) and specific home health duties in relation to hygiene for 3 of 5 records reviewed receiving home health aide services (Patients # 2, 6, and 12). Education •The Administrator/designee will conduct an in-service to all professional staff who conduct comprehensive assessments in</p>	01/06/2016

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	<p>PM, a nebulizer and disposable examination gloves were observed in the home. The patient indicated using the nebulizer for "breathing treatments." The registered nurse failed to update the plan of care to include the nebulizer and the examination gloves.</p> <p>3. On 11-23-15 at 4:30 PM, the administrator/nursing supervisor indicated not being aware the nebulizer was not listed as durable medical equipment, and examination gloves should be on each plan of care for universal precautions and infection control purposes.</p> <p>4. The clinical record of patient #2 was reviewed on 10-13-15. The clinical record evidenced a plan of care established by a physician for a start of care date of 4-22-15 with a certification period of 6-21 to 8-19-15, with order for home health aide (HHA) services "8 hours each day, 5 days each week, up to 40 hours each week ... HHA to assist/perform personal care and ADLs, prepare meals and assist with eating, keep patient 's environment clean and odor free. HHA is to call RN for any changes or concerns in patient 's condition."</p> <p>a. Review of the HHA care plan,</p>		<p>the basic principles of assessment, reassessment, CMS-mandated time frames for completion of assessments, construction of the plan of care and providing care in accordance with the plan of care.</p> <ul style="list-style-type: none"> <li>•A competent, qualified registered nurse will be assigned to each patient accepted for care by the agency.</li> <li>•The RN will conduct a comprehensive assessment of the patient at the start of care, following an inpatient stay, every sixty days and if the patient experiences a significant change in condition.</li> <li>•Patient needs will be addressed with the physician and an appropriate plan of care implemented.</li> <li>•All professional personnel will be educated on the importance of listing All DME and supplies on the POC Monitoring: Administrator or designee will perform a focused review 10 charts per week until the end of the corrective period for updated care plans, DME and supplies, specific home health aide duties and frequencies on the POC Monitoring will continue through the Quarterly clinical record review process.</li> </ul>				

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	<p>updated 6-19-15, evidenced " bed bath; complete was checked, partial was checked, no frequency was provided; perineal care as needed; shampoo as needed; dress upper and lower body; denture care daily; shave as needed; nail care-file as needed; hair care as needed; observe for reddened or open skin, apply lotion as needed; apply powder as needed; keep skin clean and dry; assist with toilet-urinal and ostomy; record bowel movements; assist with wheelchair as needed; assist with trapeze; assist with transfers as needed; transfer belt as needed; slide board as needed; turn and position every 2 hours and as needed; range of motion active and passive (no frequency); side rails up; vacuum client ' s area; dust client ' s area; clean and straighten client ' s area; make client ' s bed; change client ' s linen (no frequency); clean client ' s kitchen; wash client ' s dishes; transport to MD appointments and medically necessary. "</p> <p>b. The registered nurse failed to update the plan of care orders to obtain specific orders for home health aide duties, to include patient hygiene, type and frequency of bathing.</p> <p>5. The clinical record of patient #6 was reviewed and contained a plan of care with start of care date of 1-1-15 and a certification period of 10-28- to</p>			

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	<p>12-26-15, diagnosis of multiple, neuromuscular dysfunction of bladder and bowel, mitral valve disorder, foley catheter. The physician's plan of care orders evidenced HHA services 1 time for 1 week, 2 times a week for 8 weeks "for personal care assistance, grooming, and ADLs, patient receives personal care and homemaking services through [name of agency]: HHA 10 hours per week and homemaker 8 hours per week." HHA visit notes for the certification period were reviewed and evidenced the HHA provided a partial or full bed bath at each visit, skin care, inspection of skin integrity and for signs of pressure or redness, turned the patient while in bed, assisted patient with hoyer lift to electric wheelchair, dresses patient upper and lower body, provided incontinence care for fecal incontinence, and provided perineal care.</p> <p>6. The clinical record of patient #12 was reviewed, and evidenced a start of care 8-4-15. The clinical record contained a plan of care for the certification period 10-3 to 12-1-15 with order for HHA services up to 4 hours a visit, 3 days each week, for 9 weeks " to assist/perform personal care/ADLs/IADLs/keep patient ' s environment safe, clean, and odor free. HHA is to call RN for any changes or concerns in the patient ' s condition. "</p>			

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	<p>a. The HHA plan of care was reviewed and evidenced it was created on 8-4-15, and updated on 10-2-15. The duties delegated to the HHA were: " shower, peri care, shampoo, dress upper and lower body, oral hygiene, shave as needed, nail care, hair care, skin care; observe for reddened or open areas, apply lotion, apply powder, keep skin clean and dry, assist with toilet commode, assist with ambulation-walker, wheelchair; assist with transfers, slide board, grab bars, gait belt, turn and position, range of motion lower extremities, vacuum client ' s area, dust client ' s area, clean client ' s bathroom, clean and straighten client ' s area, make client ' s bed, do client ' s laundry, change client ' s linen, clean client ' s kitchen, wash client ' s dishes, do not transport. " The HHA plan of care failed to specify active or passive range of motion.</p> <p>b. The registered nurse failed to update the plan of care orders to obtain specific orders for the home health aide duties, to include patient hygiene and frequency of shower.</p> <p>7. On 11-23-15 at 2:30 PM, the alternate nursing supervisor verified the above findings.</p>			

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N 0604 Bldg. 00	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on record review and interview, the agency failed to ensure all home health aides reported a change in the patient's condition to the supervising nurse for 1 of 3 patients who had received home health aide services only (Patient #1).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Agency policy "Coordination of Care/Services ", dated 8-25-06, stated, "Interim HealthCare maintains regular communication with the patient/client and with others providing patient/client services. Actions and goals of Interim HealthCare Services are complimentary and reflect cooperative care planning ... the director establishes processes to document coordination of care/services in the patient/client. "</li> <li>Review of patient #1's clinical record evidenced a start of care date of 9-11-12, The clinical record contained a physician's plan of care for the certification period 4-29 to 6-27-15 with</li> </ol>	N 0604	<p>N 604 410 IAC 17-14-1(m) SCOPE OF SERVICES Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. To improve performance and bring the agency into compliance to this Standard, the following will take place: Corrective Action: Education •The Administrator/designee will conduct an in-service to licensed personnel who conduct comprehensive assessments in the basic principles of assessment, reassessment, CMS-mandated time frames for completion of assessments, construction of the plan of care and providing care in accordance with the plan of care. •The Administrator/designee will conduct an in-service to all home health aides regarding reporting any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. •A competent, qualified registered nurse will be assigned to each</p>	01/06/2016

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	<p>order for home health aide services only up to 4 hours each day, 5 days a week for 9 weeks to "assist/perform personal care/ADLS/IADLs/keep patient's environment safe, clean, and odor free, HHA is to call RN for any changes or concerns in patient's condition. A comprehensive assessment dated 4-24-15, was reviewed and evidenced patient's integumentary system was "within normal limits."</p> <p>3. Patient #1 indicated not being able to recall the date the outpatient ingrown toenail removal procedure was performed, but indicated it was in May or early June 2015. The patient stated the toenail bed healed without complication, and the HHA assigned had seen the toe and the bandage after the procedure was performed (dressing on approximately 1 week).</p> <p>4. A comprehensive assessment dated 6-23-15, was reviewed and evidenced a narrative comment by the registered nurse, "infected toe nail - removed now healed." There was no further documentation of the site of the procedure to include the appearance of the toenail bed or the size and color of the toenail bed.</p> <p>5. Home health aide (HHA) visit notes</p>		<p>patient accepted for care by the agency.</p> <ul style="list-style-type: none"> <li>The RN will conduct a comprehensive assessment of the patient at the start of care, following an inpatient stay, every sixty days and if the patient experiences a significant change in condition.</li> </ul> <p>Monitoring: Administrator or designee will perform a focused review 10 charts per week until the end of the corrective period for Accurate Oasis assessment, evidence of comprehensive assessment to include skin assessment, history of physician visits/ changes to Plan of Care. Monitoring will continue through the Quarterly clinical record review process.</p>				

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	<p>were reviewed for the certification period and failed to evidence any documentation of the patient having a toenail removal procedure, notification to the supervising nurse or the agency nursing supervisor, or any description of a dressing, the condition of the affected area during bathing. The HHA failed to coordinate services with the supervising registered nurse.</p> <p>6. On 10-13-15 at 2:30 PM, the administrator confirmed the above findings and indicated the HHAs of the agency are trained to report any change in the patients condition, to include a procedure to remove a toenail and the HHA should have notified and documented the observation to the supervising nurse when the event occurred.</p>			