

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2015
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NAME OF PROVIDER OR SUPPLIER KAYLIN'S ANGELCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 127 SOUTH STATE STREET SOUTH WHITLEY, IN 46787
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N 000 Bldg. 00	<p>This was a home health initial state licensure survey.</p> <p>Survey Dates: April 9, 10, 13, and 14, 2015.</p> <p>Facility Number: IN0013554</p> <p>Census Service Type: Skilled: 9 Home Health Aide Only: 1 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 3 RR w/o HV: 2 Total: 5</p> <p>QR:JE 4/17</p>	N 000		
N 458 Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description.</p>			

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>(2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on employee file review, policy review, and interview, the agency failed to ensure criminal background checks were performed for each employee, as required, for 1 of 7 employee files reviewed. (E)</p> <p>Findings include</p> <p>1. Employee file E, a home health aide, date of hire 2/4/15, failed to evidence a criminal background check.</p> <p>2. During interview on 4/14/15 at 10:10 AM, employee B indicated they could not find the criminal background check.</p> <p>3. The agency's undated policy titled "Background Check," # HR.002, states "The following will receive Criminal History Background Screening: ... 5. Those licensed and unlicensed individuals providing hands on care or having contact with patient's visitors, patient's property, family or family members in person."</p>	N 458	<p>Finding 1: 1. Employee E, a home health aide, date of hire February 4, 2015, an additional criminal background check completed on 4/14/15. 2. To prevent this from happening in the future Administrator will file original in HR chart and scan it into employee file on computer. 3. Administrator, is responsible for correcting this deficiency and ensuring compliance of all employee files. All files reviewed, no noted deficiencies. 4. Finding 1 was corrected on 4/14/2015. Finding 2: 1. Background check on hire date was deleted from computer. I have uploaded the receipt "ReceiptDS.pdf" dated and printed 2/4/15. 2. Administrator will file original in HR chart and scan it into employee HR file on computer. 3. Administrator, is responsible for correcting this deficiency and ensuring compliance of all employee files. 4. Finding 2 corrected 4/14/2015 Finding 3: 1. Policy titled "Background check," #HR.002, will be strictly enforced. Administrator and HR looked at new hire checklist adding criminal background check and receipt are printed and scanned. 2. Administrator will audit each new employee HR file for background check and receipt. 3. Administrator is responsible for correcting this deficiency and ensuring compliance of all HR policies. 4. Finding 3 corrected 4/14/2015</p>	04/14/2015			

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N 466 Bldg. 00	<p>410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on employee file review and interview, the agency failed to ensure employee medical information was kept separate from personnel information for 7 of 7 employee files reviewed, creating the potential to affect all the agency's employees. (A, B, C, D, E, F, and G)</p> <p>Findings include</p> <p>1. Employee file A, registered nurse, date of hire (DOH) 11/18/14, failed to evidence the medical information was kept separate from personnel information. The medical file contained copies of employee A's Tuberculosis Basic Validation card, Registered Nurse card, social security card, cardiopulmonary resuscitation (CPR) card, interview questions, employment agreement, mileage agreement, employment eligibility I-9 form, driver's license copy, payroll for for direct deposit with canceled check, voter identification</p>	N 466	<p>Findings 1:</p> <p>1. Employee file A, registered nurse, date of hire 11/18/14, Tuberculosis Basic Validation card, Registered Nurse card, Social Security card, cardiopulmonary resuscitation card, interview questions, employee agreement, mileage agreement, employment eligibility I-9 form, Driver's license copy, payroll direct deposit with canceled check, voter identification card, and W-4 form, insurance card, and fingerprints have been removed from medical file. 2. HR will separate all employee medical information and place in medical chart while keeping personnel information in the personnel chart to prevent recurrence of this deficiency. 3. Administrator and HR are responsible to maintain record according to policy. 4. Finding 1 deficiency corrected 4/15/15</p> <p>Finding 2:</p> <p>1. Employee file B, administrator, mileage agreement and employment agreement were removed from the medical file and placed into the personnel file. 2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management. 3. Administrator and HR are responsible to maintain record according to policy. 4. Finding 2 deficiency corrected 4/15/15</p> <p>Finding 3:</p> <p>1. Employee file C, a home health aide (HHA), DOH 2/16/15, criminal history request payment, Basic Life Support skills test sheet, automobile insurance payment, home health aide (HHA) registry application, W-9 form, I-9 form, driver's license, social security care, interview questions, employment agreement, mileage agreement, and HHA test has been removed from the medical file and placed in the personnel file. 2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management. 3. Administrator and HR are responsible to maintain record according to policy. 4. Finding 3 deficiency corrected 4/15/15</p> <p>Finding 4:</p> <p>1. Employee file D, human resources, DOH 3/15/15, employee D's W-9 form, I-9 form, driver's license, social security form, employment agreement, mileage agreement, and national criminal records report were removed from the</p>	04/15/2015			

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	<p>card, and, W-4 form, insurance card, and fingerprints.</p> <p>2. Employee file B, administrator, failed to evidence the medical information was kept separate from personnel information. The medical file contained mileage agreement and employment agreement.</p> <p>3. Employee file C, a home health aide (HHA), DOH 2/16/15, failed to evidence the medical information was kept separate from personnel information. The medical file contained copies of employee C's criminal history request payment, Basic Life Support skills test sheet, automobile insurance payment, home health aide (HHA) registry application, W-9 form, I-9 form, driver's license, social security card, interview questions, employment agreement, mileage agreement, and HHA test.</p> <p>4. Employee file D, human resources, DOH 3/5/15, failed to evidence the medical information was kept separate from personnel information. The medical file contained copies of employee D's W-9 form, I-9 form, driver's license, social secretary form, employment agreement, mileage agreement, and national criminal records report.</p>		<p>medical file and placed in the personnel file.</p> <p>2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management.</p> <p>3. Administrator and HR are responsible to maintain record according to policy.</p> <p>4. Finding 4 deficiency corrected 4/15/15</p> <p>Finding 5:</p> <p>1. Employee file E, a HHA, W-9 form, interview questions, employment agreement, mileage agreement, employment agreement, driver's license copy, social security card copy, CPR card, liability insurance form, and HHA test have been removed from the medical file and placed in the personnel file.</p> <p>2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management.</p> <p>3. Administrator and HR, are responsible to maintain record according to policy.</p> <p>4. Finding 5 corrected 4/15/15.</p> <p>Finding 6:</p> <p>1. Employee file F, cleaning, DOH 12/8/14, fingerprints, I-9 form, W-4 form, Driver's license copy, Social Security card, direct deposit form, resume, employment agreement, and wage change form have been removed from medical file.</p> <p>2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management.</p> <p>3. Administrator and HR are responsible to maintain record according to policy.</p> <p>4. Finding 6 corrected 4/15/15.</p> <p>Finding 7:</p> <p>1. Employee file G, alternate administrator, DOH 10/30/14, Driver's license and CPR card have been removed from medical file.</p> <p>2. A New "New Employee Orientation Check list" has been made to ensure compliance with 410 IAC 17-12-1(j) Home health agency administration/management.</p> <p>3. Administrator and HR are responsible to maintain record according to policy.</p> <p>4. Finding 7 corrected 4/15/15.</p> <p>Finding 8:</p> <p>1. At last provisional license survey all the medical records had been separated. The secretary at the time put the additional papers with personal information on them in the medical file. A new HR employee has been hired to ensure files remain compliant.</p> <p>2. Administrator and HR will audit files to ensure compliance</p> <p>3. Administrator, is responsible for maintaining compliance.</p> <p>4. All N466 findings corrected 4/15/15</p>	

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	<p>5. Employee file E, a HHA, failed to evidence the medical information was kept separate from personnel information. The medical file contained W-9 form, interview questions, mileage agreement, employment agreement, driver's license copy, social security card copy, CPR card, liability insurance form, and HHA test.</p> <p>6. Employee file F, cleaning, DOH 12/8/14, failed to evidence the medical information was kept separate from personnel information. The medical file contained copies of employee F's finger prints, I-9 form, W-4 form, driver's license, social security card, direct deposit form, resume, employment agreement, and wage change form.</p> <p>7. Employee file G, alternate administrator, DOH 10/30/14, failed to evidence the medical information was kept separate from personnel information. The medical file contained copy of driver's license and CPR card.</p> <p>8. During interview on 4/14/15 at 11:35 AM, employee B indicated they did not know the medical information had not been separated.</p>			

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N 470 Bldg. 00	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control policies & procedures for 1 of 3 home visit observations. (# 2)</p> <p>Findings include</p> <p>1. During home visit observation with patient # 2 on 4/13/15 at 8:30 AM, employee C, a home health aide (HHA), was observed providing a partial bed bath.</p> <p>A. Employee C washed and dried patient's perineal area and buttocks, then proceeded to dress patient with pants, using same gloves. Employee C failed to change the gloves prior to dressing patient.</p> <p>B. Once patient's pants were on, employee C removed gloves and donned new gloves. Employee C failed to wash hands or use hand sanitizer in between glove changes.</p>	N 470	<p>Findings 1:</p> <p>1. Employee C, a home health aide, was observed providing a partial bed bath.</p> <p>A. Employee C has been re-trained on policy QMI.019 4/20/2015. Hand washing, glove changing, and bathing clients specifically on changing gloves after washing genitalia and buttocks was reviewed with employee C.</p> <p>B. Employee C has been re-trained on policy of glove changing, and hand sanitizing or hand washing after removal of gloves.</p> <p>C. Employee C was re-trained on proper bed bath specifically on changing of bath water after washing perineal areas and buttocks as well as for armpits unless using the proper order: Head to toe, using separate wash cloths for armpits, another for perineal and buttocks, and separate washcloths for head, torso, and legs. Washcloths are not dipped back into the bath water. Employee C instructed on using separate towel for drying perineal area, buttocks and another for armpits. Employee C re-trained on proper glove changing.</p> <p>D. Employee C has been re-trained on glove changing, hand washing and proper discarding of bodily fluids.</p> <p>2. To ensure compliance employees are required to show knowledge and skill on Infection Control policies and procedures with each supervisory visit every 2 weeks starting immediately. (form uploaded HHA Supervisory visit)</p> <p>3. Administrator, is responsible for ensuring home health aide training to include Infection Control with glove changing, hand washing and hand sanitation as well as bathing.</p> <p>4. Finding 1 corrected on 4/20/2015 and will be on-going at each supervisory visit.</p> <p>Finding 2:</p> <p>1. Administrator, and employee B instructed all staff to watch the videos on infection control, hand washing and demonstrate skill. Gloves are to be changed when dirty and staff are instructed to wash hands or use hand sanitizer if clean sink is unavailable.</p> <p>2. A formal home health aide training program has been put in place to add more time and hands on training for the aides to demonstrate skills and knowledge of Infection control policy.</p> <p>3. Administrator, is responsible for the home health aide training and checkoff.</p> <p>4. Finding 2 has been corrected 4/20/2015 and will be ongoing training at hire and throughout the year.</p> <p>Finding 3:</p> <p>1. Agency policy "Infection Control Management & Assessment," #QMI.019, "5. All employees are responsible for adhering to established infection control policies and procedures during the provision of care which shall include:</p>	04/20/2015			

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	<p>C. Employee C used same water from washing patient's perineal area and buttocks to wash patient's arm pits, used same towel used to dry perineal area and buttocks to dry arm pits. Employee C then applied lotion to arms, using same gloves. Employee C failed to change gloves prior to applying lotion, and failed to change the bath water after washing perineal and buttocks areas and prior to washing patient's arm pits.</p> <p>D. Employee C assisted patient to wheel chair, donned new gloves, and handed patient urinal, then removed gloves. When patient finished urinating in urinal, employee C used balled up gloves to carry urinal to bathroom. Employee C failed to wash hands or use hand sanitizer after glove removal, and failed to don new gloves to carry urinal to bathroom.</p> <p>2. During interview on 4/14/15 at 11:05 AM, employee B, administrator, indicated all staff watch videos on infection control and hand washing on hire, and procedures are reviewed. Employee B indicated staff should wash hands or use sanitizer at beginning of patient care, and when hands are dirty. Employee B indicated staff should change gloves when they are dirty.</p>		<p>a. Hand washing, b. Proper handling of infectious waste." All staff have be given another copy of this policy, watched a demonstration of skill and performed skill for this policy. 2. Monthly training and skills checkoffs will ensure ongoing compliance with Infection control policy. 3. Administrator, is responsible for ensuring that training is scheduled and that all staff have completed monthly training. 4. Finding 3 was corrected on 4/15/2015, policy again reviewed on 4/20/2015 with staff, and training will be ongoing.</p>				

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N 494 Bldg. 00	<p>3. The agency's undated policy titled "Infection Control Management & Assessment," # QMI.019, states "5. All employees are responsible for adhering to established infection control policies and procedures during the provision of care which shall include: a. Hand washing, b. Proper handling of infectious waste."</p> <p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review, observation, agency policy review, and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient for 1 of 5 records reviewed. (# 3)</p> <p>Findings include:</p>	N 494	<p>Finding 1: 1. Clinical record #3, start of care date 4/7/2015, referring to Skilled Nurse initial evaluation dated 4/7/15 and signed by employee B (administrator). A. Consent for Service form is on the laptop computers and this was discussed with the client at start of care. Computer did not allow signature of forms on start of care date so forms were taken to home for signature 4/9/2015. Our new computer system has been challenging. We are carrying paper copies of forms in the interim until all forms are up and signature page working Information on this form was reviewed with the patient on start of care and again on 4/9/2015 B. Patients Rights form is on the laptop computers and this was discussed with the client at start of care. Computer did not allow signature of forms on start of care date so forms were taken to home for signature 4/9/2015. Our new computer system has been challenging. We are carrying paper copies of forms in the interim until all forms are up</p>	04/21/2015

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	<p>1. Clinical record #3, start of care date 4/7/15, evidenced a document titled "Skilled Nursing Initial Evaluation" dated 4/7/15 and signed by employee B (Administrator). This form stated, "Discussed with patient: Rights and Responsibilities, Patient/Caregiver Development of Care Plan, HIPAA, Notice of Privacy Practices, Charges for service/Assignment of benefits, Emergency planning in the event service is disrupted, Complaint procedure and State Hotline Number, When to contact physician and/or agency, Services provided/Anticipated Frequency, Basic home safety, Disease process, Medication regime/administration."</p> <p>A. The Consent for Service evidenced the form was not signed by the patient until 4/9/15. The record evidenced a document signed and dated by the patient on 4/9/15 titled "Consent for Service" stated, "I have received a copy and explanation of my Patient Bill of rights and the rights of the Elderly, as appropriate. I have been notified of my right to voice a complaint and understand that I may first file a complaint with the Administrator or designee at [phone number]. ... I have received an information sheet on Advance Directives including Out of Hospital DNR _____. ... I understand that this is my right and</p>		<p>and signature page working. Information on these forms were reviewed with the patient on start of care and again on 4/9/2015.</p> <p>C. Admission folder forms were not printed at the time of Admission.</p> <p>D. Client had not received an admission folder at time of Start of care. We have purchased new admission folders and have printed new forms that have been placed in the admission folders. Patient 3 has received the admission folder with the new forms 4/25/2015.</p> <p>E. Employee B was incorrect about patient #3receiving a physical copy of the patients rights, and consent form on the admission dates. The information on these forms was reviewed with patient #3 verbally. A copy of these forms was given to patient #3 with the admission folder. Clinical record #3 has been updated with client packet given to client 4/25/2015 to include updated ISDH Advanced Directives.</p> <p>2. Agency has new computer software. Agency has made copies of consent forms & patient rights forms for each nurse to have in computer bag and are working with the software technical team to ensure forms with signature page are working properly. Administrator and staff have been in-serviced on policy #CLN.007, annual in-service training on start of care policies and there will be ongoing computer training on signature pages for start of care.</p> <p>Finding 2:</p> <p>1. Policy "Maintaining Patient Rights & Regulation," #CLN.007, has been reviewed with all staff to include admission rights of patient to have consent form, patient rights form and forms of acknowledgement of receipt of these forms.</p> <p>2. To ensure future compliance agency will ensure all admit packets are complete and correct and given to admitting nurse prior to admission. Admitting nurse will pick up admission packet prior to admission. In-service will be performed as needed to ensure compliance.</p> <p>3. Administrator, is responsible for all paperwork at start of care including consent and patient rights and that staff are properly trained on completion of admission forms.</p> <p>4. Finding 2 deficiencies completed 4/9/2015 and 4/25/2015.</p> <p>Finding 3:</p> <p>1. Administrator reviewed policy #CLN.001 Admission Course of Action. Administrator made copies of admission forms to have with nurse for admission.</p> <p>2. To ensure future compliance agency will ensure all admit packets are complete and correct and given to admitting nurse prior to admission. Admitting nurse will pick up admission packet prior to admission. In-service will be performed as needed to ensure compliance.</p> <p>3. Administrator, is responsible for all paperwork at start of care including consent and patient rights and that they are discussed and signed at start of care and that computer systems and software are working properly.</p> <p>4. Finding 1 deficiencies completed 4/25/2015</p>	

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	<p>responsibility to be involved in my care and that I will be informed as to the nature and purpose of any technical procedures. ... I have been informed verbally and in writing regarding Agency policy on abuse, neglect and exploitation, agency drug testing policy a and hazardous waste disposal in home. I have been advised verbally and in writing the purpose and my rights pertaining to the collection of OASIS information and the OASIS Privacy Act. HIPAA- I have received a Notice of Privacy Practices and consent to the agency's use and/or disclosure of protected health information for payment, treatment and Agency's Health care operations."</p> <p>B. The record evidenced the document titled "Patient Rights" was not signed by the patient until 4/9/15.</p> <p>C. During home visit observation on 4/13/15 at 1:00 PM, patient # 3 indicated they did not know the location of their admission folder from the agency.</p> <p>D. During home visit observation on 4/13/15 at 1:05 PM, employee B, the administrator, indicated they had not brought the admission folder to the patient's home yet.</p> <p>E. During interview on 4/14/15 at</p>			

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NAME OF PROVIDER OR SUPPLIER KAYLIN'S ANGELCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 127 SOUTH STATE STREET SOUTH WHITLEY, IN 46787
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	<p>11:30 AM, employee B indicated patient # 3 received a copy of the patient rights, and consent form on admission dates, but not the admission folder with the Advance Directives information.</p> <p>2. The agency's undated policy titled "Maintaining Patient Rights & Regulation," # CLN.007, states, "It shall be the policy of the Agency to: 1. Implement and enforce all State and Federal regulations related Indiana Patient. ... 2. Promote patient interest and well-being by informing them of their rights, both written and orally. ... Procedures: 1. Each patient admitted is given written and verbal information regarding rights in a language they can understand by the admitting nurse regarding any care being rendered. The admitting professional reviews the Indiana Patient rights with the patient. 2. The patient or caregiver signs an acknowledgement of receipt of the information. 3. The original signed acknowledgement is placed in the patient's medical record in the agency and a copy placed in the patient's home folder. 4. Updates on Indiana Patient rights may be reviewed periodically with staff as updates and changes occur."</p> <p>3. The agency's undated policy titled "Admission Course of Action," #</p>			

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N 518 Bldg. 00	<p>CLN.001, states, "During the initial assessment/visit, the Registered Nurse shall ensure the following completed: ...</p> <p>2. Upon admission all patients shall be instructed on the Home Health Agency's services, Indiana Patient Rights, ... Advance health Care Directive. ... 3. These instructions shall be given to the patient verbally in a language that he or she can understand. Written copies shall be distributed to each patient/caregiver."</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on admission packet review, home visit observation, policy review, and interview, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, for 1 of 3 active patient observations. (# 1, 2, and 3)</p>	N 518	Finding 1: 1. Agency admissions folder of information given to patients at start of care (SOC), has been updated to the current State of Indiana Advanced Directives packet, revised July 2013 and all patients have been mailed a copy of the revised packet. A new patient checklist was also made to reflect this change. 2. To ensure that the	04/20/2015

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	<p>Findings include</p> <ol style="list-style-type: none"> 1. The agency admission folder of information, given to patients at start of care (SOC), failed to include the updated State of Indiana Advanced Directives packet, revised July 1, 2013. 2. During home visit with patient #1 on 4/9/15 at 12:20 PM, the patient's family member indicated they did not know the location of the admission folder. 3. On 4/13/15 at 8:30 AM, the home admission folder was observed during a home visit for patient # 2. The folder evidenced the Advance Directives packet was dated May, 2004. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013. 4. During home visit observation on 4/13/15 at 1:00 PM, patient # 3 indicated they did not know the location of their admission folder from the agency. <p>During home visit observation on 4/13/15 at 1:05 PM, employee B, the administrator, indicated they had not brought the admission folder to the patient's home yet.</p> <ol style="list-style-type: none"> 5. The agency's undated policy titled 		<p>Indiana State Advanced Directives packet is up to date, Administrator will check the ISDH website for updates. 3. Administrator, is responsible for ensuring the Indiana State Advanced Directives are up to date. 4. Finding 1 deficiency completed 4/21/2015 Finding 2: 1. Patient #1 did have an admission folder on the small table next to the kitchen table. Due to condition of patient at time, Administrator did not press caregiver to get the folder. 2. Administrator trained staff to instruct patients to keep admission folder in same place so when copies of completed forms are sent to patient, they can place in the admissions folder. 3. Administrator, is responsible for training staff to instruct patients to keep admission folder in place easily accessible to staff. 4. Finding 2 deficiency completed 4/21/2015 Finding 3: 1. Patient #2 was sent a revised copy of the Indiana State Advances Directives from July 1, 2013. 2. Administrator will continue to check the ISDH website for updates to Indiana State Advanced Directives form. 3. Administrator, is responsible for ensuring Indiana State Advanced Directives are current. 4. Finding 3 deficiency completed 4/21/2015 Finding 4: 1. Patient #3 was given an admissions folder. 2. Administrator will ensure admission folders are complete</p>				

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	<p>"Admission Course of Action," # CLN.001, states, "During the initial assessment/visit, the Registered Nurse shall ensure the following completed: ...</p> <p>2. Upon admission all patients shall be instructed on the Home Health Agency's services, Indiana Patient Rights, ... Advance health Care Directive. ... 3. These instructions shall be given to the patient verbally in a language that he or she can understand. Written copies shall be distributed to each patient/caregiver."</p> <p>6. The agency's undated policy titled "Maintaining Patient Rights & Regulation," # CLN.007, states, "It shall be the policy of the Agency to: 1. Implement and enforce all State and Federal regulations related Indiana Patient. ... 2. Promote patient interest and well-being by informing them of their rights, both written and orally. ... Procedures: 1. Each patient admitted is given written and verbal information regarding rights in a language they can understand by the admitting nurse regarding any care being rendered. The admitting professional reviews the Indiana Patient rights with the patient. 2. The patient or caregiver signs an acknowledgement of receipt of the information. 3. The original signed acknowledgement is placed in the patient's medical record in the agency and</p>		<p>and available at time of admission for nurses to give to patients. 3. Administrator, is responsible for ensuring patients receive admissions folder. 4. Finding 4 deficiency completed 4/25/2015</p> <p>Finding 5: 1. Administrator reviewed policy #CLN.001 Admission Course of Action. Administrator made copies of admission forms to have with nurse for admission. In-service provided to nurses. 2. To ensure future compliance agency will ensure all admit packets are complete and correct. In-service will be performed as needed to ensure compliance. 3. Administrator, is responsible for Compliance with Admission policies. 4. Finding 5 deficiency completed 4/25/2015</p> <p>Finding 6: 1. Maintaining Patient Rights & Regulation policy CLN.007-Administrator has reviewed the policy. Administrator reviewed all charts for compliance. Administrator reviewed with patient #3. 2. Administrator to prepare admission paperwork to include all forms required by policy CLN.007. Monthly audits will be done on all patient charts for the next 6 months to ensure ongoing compliance. 3. Administrator is responsible to ensure patients rights. 4. Finding 6 deficiency completed 4/20/2015</p>	

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N 522 Bldg. 00	<p>a copy placed in the patient's home folder. 4. Updates on Indiana Patient rights may be reviewed periodically with staff as updates and changes occur."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care for 2 of 5 records reviewed. (# 2, and 4)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care (SOC) date 2/11/15, contained a Skilled Nursing Initial Evaluation/Assessment and Plan of treatment orders, faxed to the physician for the certification period 2/12-4/8/15 with orders for Home Health Aide (HHA) 3 times per day Sunday thru Thursday and 1 time per day on Friday.</p> <p>A. The record failed to evidence HHA visits were provided on 2/12/15 afternoon, 2/14/15 afternoon, 2/15/15</p>	N 522	<p>Finding 1: 1. Clinical record #2, SOC date 2/11/15, certification period and duration incorrect. Administrator corrected on 485. A. Missed Visit form filled out for 2/12/15 afternoon, 2/14/15 afternoon, 2/15/15 morning, 2/19/15 morning, 2/28/15 afternoon, 3/7, 8, 14 and 15 all day, 3/24/15 evening, and 4/5/15 afternoon and faxed to physician. B. Spouse paid for privately for care on 3/7, 8, 14, and 15, and on 2/12 and 2/19 the hospice aide provided care, and on 3/24 and 4/5 the spouse did not need help those days. Physician notified of this. 2. To ensure Missed HHA visit forms are completed and sent to physician, Administrator will audit HHA charts Monthly over next 6 months. 3. Administrator is responsible for physician notification of missed visits. 4. Finding 1 deficiency</p>	04/20/2015

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	<p>morning, 2/19/15 morning, 2/28/15 afternoon, 3/7, 8, 14, and 15 all day, 3/24/15 evening, and 4/5/15 afternoon, and and failed to evidence the physician was notified of any missed visits.</p> <p>B. During interview on 4/10/15 at 12:55 PM, employee B, the administrator, indicated those days the spouse paid for private duty care on 3/7, 8, 14, and 15, and on 2/12 and 2/19 the hospice aide provided care, and on 3/24 and 4/5 the spouse did not need help those days.</p> <p>2. Clinical record # 4, SOC 1/13/15, contained a Skilled Nursing Initial Evaluation/Assessment and Plan of treatment orders, signed by the physician on 1/14/15 for the certification period 1/13-3/13/15 with orders for skilled nurse (SN) 1 time a week for 9 weeks.</p> <p>A. The record failed to evidence a SN visit was provided the week of 3/1-3/7/15 and failed to evidence the physician was notified of the missed visit.</p> <p>B. During interview on 4/13/15 at 11:20 AM, employee B indicated the patient had an appointment the week of the missed visit, but the agency did not complete a missed visit form.</p>		<p>completed 4/20/2015. Finding 2: 1. Clinical record #4, SOC, 1/13/15, certification period with orders for SN 1W1 - W9. A. Missed Visit form was completed for week of 3/1-3/7/15 and faxed to physician. B. Patient had a Dr. appointment with primary physician. Missed visit form faxed to physician. 2. To ensure Missed HHA visit forms are completed and sent to physician, Administrator will audit HHA charts Monthly over next 6 months. 3. Administrator is responsible for physician notification of missed visits. 4. Finding 2 deficiency completed 4/20/2015.</p> <p>Finding 3: 1. Missed Visit forms are now consistently being completed and faxed to physician for notification. 2. To ensure Missed HHA visit forms are completed and sent to physician for notification, Administrator will audit HHA charts Monthly over next 6 months. 3. Administrator is responsible for physician notification of missed visits and completion of missed visit forms. 4. Finding 3 deficiency completed 4/20/2015.</p> <p>Finding 4: 1. Policy Medical Records & Documentation, #CLN.027, reviewed with all clinical staff and an in-service instructing on completion of both paper and computer form was given on 4/20/2015. 2. To ensure Policy CLN.027 is adhered to, Administrator will audit all charts Monthly over next 6 months. 3. Administrator is responsible for compliance staff compliance with policy 4. Finding 4 deficiency completed 4/20/2015.</p>				

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N 524 Bldg. 00	<p>3. During interview on 4/10/15 at 11:00 AM, employee B, the administrator, indicated they have not been completing missed visit forms nor notifying the physicians of missed visits.</p> <p>4. The agency's undated policy titled "Medical Records & Documentation," # CLN.027, states "H. Missed Visits are documented on the Missed Visit form with reasons for missed visit and Follow-up as required. The physician will be notified of the Missed Visit and the date and time of notification will be documented on the form."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements.</p>			

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	<p>(ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included duration of time for visits, failed to ensure dates for the time frame of the care period were correct, failed to include all medications taken by patients, failed to ensure all durable medical equipment (DME) were listed, and failed to ensure nutritional information were correct for 3 of 5 clinical records reviewed. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record # 1, start of care (SOC) date 2/16/15, contained a Plan of Care (POC) for the care period 4/3-5/19/15, with the SOC date listed as 4/3/15.</p> <p>A. The Skilled Nursing Initial Evaluation/Assessment and Plan of Treatment orders dated 2/16/15 stated "Certification period from 2/16/15-4/12/15." The care period should have been dated 2/16-4/16/15.</p>	N 524	<p>Finding 1: 1. Clinical record #1, SOC date 2/16/2015, plan of care for care period has been corrected and faxed to physician and return with physician signature. A. Skilled Nurse Initial Evaluation/Assessment and Plan of Treatment orders dated 2/16/15 has been corrected to reflect care period 2/16-4/16/15. B. Consent for services is correctly signed on 2/16. C. Medication Profile dated 2/16/15 and POC have been corrected to reflect all medications. D. Medication Profile dated 2/16/15 and POC have been corrected to reflect that route of potassium cl 10% 20 meq daily per PEG tube. E. POC corrected to reflect PEG tube, Jevity, and Nutritional requirement of pureed diet. 2. To ensure POC of each patient is correct Administrator and staff will utilize the new software to input medications, DME and diet. Administrator will audit each POC going forward. 3. Administrator is responsible for ensuring POC is correct prior to sending to physician. 4. Finding 1 deficiency completed 4/20/2015. Finding 2: 1. New computer system has been updated to bring medication</p>	04/20/2015

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	<p>B. The Consent for Services was signed on 2/16/15.</p> <p>C. The Medication Profile dated 2/16/15 listed medications as: Transderm-scope 1.5 milligrams (mg) every 72 hours, Fluticasone Prop 50 micrograms (mcg) daily via nares, Alprazolam 0.5 mg three times a day as needed orally, Mucinex 600 mg daily orally, Omeprazole DR 20 mg daily orally, Mult Vitamin daily orally, Amlodipine 5 mg daily orally, Zolofit 100 mg twice daily orally, Nyedexta 20-10 every 12 hours orally, Levothyroxine 200 mg daily orally, and Losartan Potassium 50 mg daily orally. The POC failed to evidence these medications.</p> <p>D. The Medication Profile dated 2/16/15 listed Potassium Cl 10% 20 miliequivalents (mEq) daily per peg tube. The POC stated Potassium 20 mEq orally daily.</p> <p>E. The Skilled Nursing Initial Evaluation/Assessment and Plan of Treatment orders dated 2/16/15 stated "Mouth condition: Difficulty Swallowing, Chokes, Aspirates, ... Gastrointestinal: peg, Jevity when needed, ... Digestive Interventions: Parenteral nutrition and the use of</p>		<p>forward into POC. 2. To ensure POC of each patient is correct Administrator and staff will utilize the new software to input medications and review medication profile at each visit. Administrator will audit each POC medications going forward. 3. Administrator is responsible for ensuring POC medications are correct. 4. Finding 2 deficiency completed 4/20/2015. Finding 3: 1. Clinical record #2, SOC dated 2/11/2015, POC has been corrected to reflect 2/11-4/11/15. A. POC has been corrected to reflect frequency & duration of HHA services and sent to physician for signature. B. POC has been corrected and faxed to physician to reflect all medications. C. POC has been corrected and faxed to physician to reflect nutritional requirements of thickened liquids per SN Initial Assessment. D. All staff have reviewed policy on physician orders and an in-service on nutritional requirements. 2. To ensure POC contains correct information all POC will be audited going forward. 3. Administrator is responsible for audit of POC 4. Finding 3 deficiency completed 4/20/2015 Finding 4: 1. Clinical record #4, SOC date 4/7/2015, POC corrected to reflect are period 4/7-6/5/15 and faxed to physician. 2. To ensure POC</p>				

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	<p>equipment, gravity, ... Nutrition/Hydration: diet: pureed, difficulty chewing/swallowing, ... Nutritional requirements new or changed: mechanical, peg tube."</p> <p>The POC failed to evidence the peg tube, Jevity, and stated Nutritional Requirements "Regular as tolerated."</p> <p>2. During interview on 4/10/15 at 9:55 AM, employee B, the administrator, indicated they entered the medication list for patient #1 but went by what was told to her on 4/9 by the patient's family, the computer system is new and they have recently been able to create the POC, and the drugs were missing from the SOC list due to the POC was not bringing over all the information.</p> <p>3. Clinical record # 2, SOC date 2/11/15 contained a POC dated 3/30-5/22/15. The care period should have been dated 2/11-4/11/15.</p> <p>A. The POC contained orders for home health aide (HHA) three times per day Sunday thru Thursday 8:00-10:00 AM, 2:00-3:00 PM, and 9:00-10:00 PM, and 1 time per day on Friday. The POC failed to contain a duration for the HHA services.</p>		<p>contains correct information all POC will be audited going forward. 3. Administrator is responsible for audit of POC 4. Finding 4 deficiency completed 4/20/2015 Finding 5: 1. Agency policy Patient Plan of Care, #CLN.009 has been reviewed by all staff and an in-service given with a OASIS 2015 calendar and how to read it. 2. To ensure POC contains correct information all POC will be audited going forward. 3. Administrator is responsible for audit of POC 4. Finding 4 deficiency completed 4/20/2015 Finding 6: 1. Agency policy Medical records & Documentation CLN.027, Plan of are reviewed by all staff and an in-service on Documentation provided 4/20/2015. 2. To ensure policy compliance and POC contains correct information all POC will be audited going forward. Annual in-service for documentation 3. Administrator is responsible for policy compliance 4. Finding 6 deficiency completed 4/20/2015 Finding 7: 1. Agency policy titled Admission course of Action, CLN.001 has been reviewed by all staff and an in-service provided for frequency & duration of visits. 2. To ensure policy compliance POC will be audited going forward. 3. Administrator is responsible for policy compliance 4. Finding 7 deficiency completed 4/20/2015</p>	

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	<p>B. The POC failed to include all medications as listed on the Medication Administration Record dated March 2015: Glucagen EQ 1 mg base/vial 1 injectable injection as needed, and Novolog 100 units subcutaneous every 12 hours.</p> <p>C. The POC listed nutritional requirement as low sugar. The Skilled Nursing Initial Evaluation/Assessment and Plan of Treatment orders dated 2/11/15 stated, "Mouth Condition: difficulty swallowing, ... Digestive interventions: thicken liquids/ground, ... Nutrition/Hydration: diet: nectar thick liquids, ground meat, difficulty chewing/swallowing, nutritional risk moderate."</p> <p>D. During interview on 4/10/15 at 12:40 PM, employee B indicated the admitting nurse probably took the information for the diet from the skilled nursing facility discharge instructions, and the patient's souse refuses to follow that diet, only wants to follow low sugar diet.</p> <p>4. Clinical record # 4, SOC date 4/7/15 contained a POC date 4/7-5/22/15. The care period should be 4/7-6/5/15.</p> <p>5. The agency's undated policy titled</p>						

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	<p>"Patient Plan of Care," # CLN.009, states, "1. The admitting nurse develops the patient's Plan of Care based on his/her initial assessment finding in coordination with the physician, home health care staff, and interdisciplinary team members. 2. The Initial Plan of Care is developed within (5) working days of the initiation of home care services. ... 4. The Plan of Care should include: ... (b) Type of home health care services and equipment required, ... (k) Medication, (l) Special diet, ... (r) Medical supplies/appliances necessary."</p> <p>6. The agency's undated policy titled "Medical records & Documentation," # CLN.027, states, "J. Contents of the medical record shall include but not be limited to the following: ... d. Care Plan or Plan of Care. The Plan of Care shall include, as applicable, medication, dietary, treatment, and activity orders."</p> <p>7. The agency's undated policy titled "Admission Course of Action," # CLN.001, states, "During the initial assessment/visit the Registered Nurse shall ensure the following completed: ... 9. ... The plan of care must include the services to be rendered and the frequency and duration of the visits."</p>			

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N 542 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a)(1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse (RN) revised the plan of care to include new and discontinued medications for 1 of 5 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1, start of care date 2/16/15, contained a Medication Profile signed by the RN on 2/16/15.</p> <p>A. The Nursing Visit Record dated 3/5/15 evidenced the patient had a new medication since last visit: Cephalexin 500 milligrams (mg), 2 every 12 hours. The Medication Profile failed to evidence this was updated on 3/5/15.</p> <p>B. The Nursing Visit Record dated 3/29/15 evidenced the patient had a new medication since last visit: Tramadol 50 mg every 6 hours as needed. The Medication Profile failed to evidence this</p>	N 542	<p>Findings 1: 1. Clinical record #1, start of care date 2/16/15, Medication Profile corrected and faxed to doctor A. Nursing Visit Record dated 3/5/2015 evidenced the patient had a new medication and medication profile has been corrected to reflect changes and faxed to doctor. Clinical record #1 continued: B. Nursing Visit Record dated 3/5/15 evidenced a new medication, Tramadol 50mg every 6 hours as needed, and this has been corrected on medication profile to reflect new medication. C. Skilled Nurse Initial Evaluation/Assessment and Plan of treatment Orders sheet dated 2/11/15 did not state any wound (RN failed to assess on admission). Initial Evaluation dated 4/6/2015, stated Wound Type: Pressure Ulcer to right inner butt cheek....Duoderm was requested from hospice agency. D. This form has been corrected to read Interim Evaluation. 2. To prevent this deficiency going forward,</p>	04/20/2015

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	<p>was updated on 3/29/15.</p> <p>C. The Skilled Nurse Initial Evaluation/Assessment and Plan of treatment orders sheet dated 2/11/15 stated, "Skin: wounds, ulcers, incisions: N/A [not applicable]." An Initial Evaluation dated 4/6/15, completed by employee B, stated "Wound Care: Wound Type: Pressure ulcer to right inner butt cheek is red around and has white center. Duoderm requested from [hospice agency] nurse. ... Dimensions (Length, Width, Depth): Length 1 centimeter (cm), Width 1 cm, Depth .25 cm."</p> <p>D. During interview on 4/10/15 12:30 PM, employee B indicated patient # 3 was referred by spouse, came from a skilled nursing facility, and had this right butt cheek wound on admission to the agency, and apparently the RN failed to assess the wound on admit. Employee B also indicated the form titled "Initial Evaluation" was an interim evaluation for the next certification period and is mis-labeled.</p> <p>2. During interview on 4/10/15 at 9:50 AM, employee B, administrator, indicated the medications from 3/5 and 3/29 were not added to the medication profile.</p>		<p>all clinical staff have been in-serviced on head-to-toe assessments, wounds will be followed throughout course of certification period to ensure assessments, doctor notifications, and medication administration. 3. Administrator is responsible to ensure all clinical staff are in-serviced, documentation is complete, and medication profiles are updated. 4. Finding 1 deficiency completed on 4/20/15 Finding 2: 1. Medications from 3/5 and 3/25 have been added to the medication profile. 2. To prevent overlooking new medications in the future the nurse will use the new computer software to enter any new medications to the medication profile at the time of visit. An audit of medication profiles will be done with monthly audits. 3. Administrator is responsible for ensuring new medications are added to medication profile. 4. Finding 2 deficiency completed 4/20/2015 B. Nursing Visit Record dated 3/5/15 evidenced a new medication, Tramadol 50mg every 6 hours as needed, and this has been corrected on medication profile to reflect new medication. C. Skilled Nurse Initial Evaluation/Assessment and Plan of Treatment Orders sheet dated 2/11/15 did not state any wound (RN failed to assess on admission). Initial Evaluation dated 4/6/2015, stated Wound Type: Pressure Ulcer to</p>				

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	<p>3. The agency's undated policy titled "Medication worksheet & Schedule," # CLN.022, states, "1. Medication sheets are established at the time of admission and updated as the physician alters the patient's medication regimen. 2. Agency nursing staff shall assess each patient's medication regimen for possible ineffective drug therapy and discuss any problems with the patient's physician. 3. Using the Medication sheet, the nurse enters physician's name, patient's name, date of admission visit or the date on which the Medication Sheet was updated."</p> <p>4. The agency's undated policy titled "Admission Course of Action," # CLN.001, states, "During the initial assessment/visit the Registered Nurse shall ensure the following completed: ...</p> <p>6. Conduct a physical examination including total system review."</p>		<p>right inner butt cheek...Duoderm was requested from hospice agency. D. This form has been corrected to read Interim Evaluation. 2. To prevent this deficiency going forward, all clinical staff have been in-serviced on head-to-toe assessments, wounds will be followed throughout course of certification period to ensure assessments, doctor notifications, and medication administration. 3. Administrator is responsible to ensure all clinical staff are in-serviced, documentation is complete, and medication profiles are updated. 4. Finding 1 deficiency completed on 4/20/15 Finding 2: 1. Medications from 3/5 and 3/25 have been added to the medication profile. 2. To prevent overlooking new medications in the future the nurse will use the new computer software to enter any new medications to the medication profile at the time of visit. An audit of medication profiles will be done with monthly audits. 3. Administrator is responsible for ensuring new medications are added to medication profile. 4. Finding 2 deficiency completed 4/20/2015 Finding 3: 1. Agency policy Medication worksheet & Schedule, #CLN.022, reviewed with clinical staff. All charts audited to reflect medication changes. 2. To prevent deficiency in the future audits of medication profiles will</p>				

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N 608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.		be done monthly. 3. Administrator is responsible that policy CLN.022 is adhered to. 4. Finding 3 deficiency completed 4/20/2015 Finding 4: 1. Agency policy Admission Course of Action, #CLN.001, 6. Conduct a physical examination including total system review. Clinical staff in-serviced on full assessment and policy #CLN.001. 2. To prevent future deficiency all clinical staff will read through policy and perform full assessment as check-off prior to seeing patients alone 3. Administrator is responsible for ensuring Admission Course of Action is adhered to. 4. Finding 4 deficiency completed 4/20/2015	

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	<p>(6) A discharge summary. Based on clinical record review, policy review, and interview, the agency failed to ensure a discharge summary was completed for each patient discharged from the agency for 1 of 1 discharge record reviewed. (# 5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 3/4/15, contained a Skilled Nursing Initial Evaluation/Assessment and Plan of treatment orders sheet with orders for Skilled Nurse visits 1 time a week for 1 week, single visit. This patient showed up on the agency discharge list with a discharge dated of 3/4/15. The clinical record failed to evidence a discharge summary had been completed.</p> <p>2. During interview on 4/13/15 at 11:15 AM, employee B, the administrator, indicated this patient was admitted and discharged the same day, as the patient indicated they did not want more visits. Employee B indicated they did not do a discharge summary, just wrote the order to be a single visit, and that they did notify the physician while in the office that same day.</p> <p>3. The agency's undated policy titled "Patient Discharge," # CLN.035, states,</p>	N 608	<p>Findings 1: 1. Clinical Record #5, start of care date 3/4/15, Plan of treatment showed single visit. Discharge Summary was completed and sent to physician.</p> <p>2. To prevent future deficiency Policy CLN.035, patient discharge, will be adhered to immediately. Discharge summary will be added to client check off list. (uploaded Discharge Checklist) To ensure compliance all potential discharge patients will have a reminder sent to assigned nurse.</p> <p>3. Administrator is responsible for compliance.</p> <p>4. Finding 1 deficiency corrected 4/15/2015</p> <p>Finding 2:</p> <p>1. Client admitted and discharged the same day. Client did not want further visits. Discharge summary completed and faxed to physician.</p> <p>2. To prevent deficiency in future a single visit form that includes a discharge summary will be used.</p> <p>3. Administrator responsible for compliance with policy Patient Discharge CLN.035.</p> <p>4. Finding 2 deficiency corrected 4/20/2015.</p> <p>Finding 3:</p> <p>1. Agency Policy Patient Discharge, # CLN.035, has been reviewed by clinical staff. Corrected discharge to include discharge summary for Client #5, faxed to physician.</p> <p>2. To prevent deficiency in future, audit of all discharge charts will be done to ensure discharge summary has been done.</p> <p>3. Administrator is responsible for policy compliance.</p> <p>4. Finding 3 deficiency corrected 4/20/15.</p>	04/15/2015			

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	"f. The physician will be made aware that a copy of the discharge summary is available if she/he desires to receive one. ... Discharged Records: Discharged records are in the same chart order as the active records with one exception: The completed discharge summary precedes all other documents in the chart."						