

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157559	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2015
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NAME OF PROVIDER OR SUPPLIER HEALTHSET	STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714
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G 0000 Bldg. 00	<p>The was a Federal recertification survey. The survey was extended.</p> <p>Survey dates: 09/15/15 to 09/18/15</p> <p>Facility ID#: 003563</p> <p>Medicaid #: 200450280</p> <p>Provider #: 157559</p> <p>Census: 9</p> <p>Healthset is precluded from providing its own training and competency evaluation program for a period of 2 years beginning September 18, 2015 to September 18, 2017, for being found out of compliance with the Condition of Participation 484.12 Compliance with Accepted Professional Standards and Principles; 484.14 Organization, Services, and Administration; 484.30 Nursing Service; 484.36 Home Health Aide; and Condition of Participation 484.55 Comprehensive Assessment.</p>	G 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 0108 Bldg. 00	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on record review and interview, the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 4 of 9 records reviewed. (#2, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC (start of care) 12/15/14. The Admission Service Agreement dated 12/15/14, indicated the patient was to receive home health aide services for bathing and ADLs (activities of daily living). The Admission Service Agreement failed to evidence the frequency of the proposed visits.</p>			G 0108	<p>G108 The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of the care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits, client and agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to care and services provided by the agency and specify these on the Admission Service Agreement in terms that the patient can understand. Admission service agreements have been updated and provided to patients in accordance with these stipulations as well as verbal explanation of the informed consent, client and agency responsibilities for care and services including the cost of care</p>		10/06/2015

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	<p>2. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive home health aide services three times a week and homemaker services two times a week. The "Planned Treatment" was left blank. The Admission Service Agreement failed to evidence the scope of services that was to be provided by the home health aide and homemaker. The Admission Service Agreement failed to evidence the length of services to be provided.</p> <p>3. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive physical therapy and occupational therapy. The Admission Service Agreement failed to evidence the frequency proposed and plan of treatment for physical and occupational therapy.</p> <p>4. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing three times a week for "assessment, medication administration per 485." The Admission Service Agreement failed to specify in terms that the patient can understand (485) for planned treatment and failed to specify duration of services to be provided.</p>		<p>and any financial responsibility of the client related to care and services provided by the agency. 100% of patient charts will be audited quarterly thereafter for evidence that patients were informed of the care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits, and that these are specified on the Admission Service Agreement in terms that the patient can understand. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>5. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>6. An undated policy titled Client Rights indicated, " ... The client has the right to be informed about the care to be furnished, and of any changes in the care to be furnished ... "</p> <p>7. An undated policy titled Informed Consent indicated, "An informed consent will be explained to and signed by all clients or the client's legal representative prior to admission. Explanation of the informed consent ensures that all client / families are informed about the type of care and services provided during the course of illness and that the client / family consent to such ... "</p> <p>8. An undated policy titled Client Rights / Responsibilities indicated, " ... On admission and as often as necessary, verbally and in writing, client and Agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to the care / services provided by the Agency will be provided to the client / caregiver(s) ... "</p>			

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G 0110 Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 9 of 9 clinical records reviewed (#1 - 9).</p> <p>Findings</p> <p>1. The admission folder that are provided to patients was reviewed on 09/15/15. The admission folder failed to include an updated July 2013 version of the 2004 Indiana Advanced Directives document as well as the agency policy.</p> <p>2. Interview on 9/18/15 at 4:45 PM, the Administrator, acknowledged the</p>	G 0110	G 110 The Supervising Registered Nurse has updated all Admission packets with the current July 2013 version of the 2004 Indiana Advanced Directives as well as the agency's policy on Advance Directives. All patients have received the updated July 2013 version of the 2004 Indiana Advanced Directives as well as the agency Policy on Advance Directives. The Supervising Registered Nurse will perform monthly audits for three quarters to ensure that the Admission packet provided to patients, contain a copy of the agency's policy on Advanced Directives and that the Advance Directives brochure distributed to patients is the effective and current advanced directives (effective May 2004 and revised	10/06/2015

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	<p>advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. Clinical record #1, SOC (start of care) date 11/27/13, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>4. Clinical record #2, SOC date 12/15/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>5. Clinical record #3, SOC date 06/24/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>6. Clinical record #4, SOC date 09/29/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>7. Clinical record #5, SOC date 09/25/12, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.</p> <p>8. Clinical record #6, SOC date 02/13/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.</p>		<p>July 1, 2013). The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>7. Clinical record #7, SOC date 01/13/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.</p> <p>8. Clinical record #8, SOC date 07/30/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.</p> <p>9. Clinical record #9, SOC date 04/13/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.</p> <p>10. The Administrator was interviewed on 09/17/15 at 12:30 PM. The Administrator stated patient #2 had known what his / her payor source was and the patient was receiving Medicare, Medicaid, and Medicare services.</p> <p>11. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>12. An undated policy titled Client Rights indicated, " ... The agency shall inform and distribute written information to the client, in advance, concerning its policies on advance directives, including</p>			

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G 0114 Bldg. 00	<p>a description of applicable State Law. The agency shall furnish advanced directives information to a client at the time of the first home visit before care is provided ... "</p> <p>484.10(e)(1(i-iii)) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. Based on clinical record review and interview, the agency failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 9 of 10 records reviewed. (#1 - 4, 6 - 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13. The Admission Service Agreement dated 11/27/13, indicated "Charge: 0." The Amount Insurance pays and the amount the patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not</p>	G 0114	G 114 The Supervising Registered Nurse has in serviced professional staff on notifying patients on admission and as often as necessary, verbally and in writing the charges for services, client and agency responsibilities for care and any financial responsibilities including the costof care and charges. Admission service agreements have been updated to include the cost of care and any financial responsibility of the client related to care and services provided by the agency in terms that the patient can understand and has been provided to patients as well as verbal explanation of agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to care and	10/06/2015

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	<p>covered by the insurance benefit.</p> <p>2. Clinical record #2, SOC date 12/15/14. During a home visit on 09/16/15 at 08:00 AM, the patient had stated that she did not know if the services she was receiving was under Medicare, Medicaid, and / or Waiver services. The Admission Service Agreement dated 11/27/13, the Charge section, amount insurance pays, and amount patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>3. Clinical record #3, SOC date 06/24/15. The Admission Service Agreement dated 06/24/15, indicated "Charge: 0 / Amount Insurance Pays: Medicare rate / Amount patient pays: 0." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>4. Clinical record #4, SOC 09/24/14. The Admission Service Agreement dated 09/24/14, indicated "Charge: 0 / Amount Insurance Pays: Per Medicaid Notes / Amount Patient Pays: Per spenddown if applicable." The Admission Service Agreement failed to evidence charges</p>		<p>services provided by the agency. 100% of patient charts were audited by 10/06/2015 and will be audited quarterly thereafter for evidence that patients were notified upon admission in the Admission service agreement, verbally, and as often as necessary of the charges for services, client and agency responsibilities for care and any financial responsibilities including the cost of care and charges for services that may not be covered and that the individual may have to pay. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>that may occur for services not covered by the insurance benefit.</p> <p>5. Clinical record #6, SOC 02/13/14. The Admission Service Agreement dated 02/13/14, indicated "Charge: 0 / Amount Insurance Pays: Per [Name of council on aging agency] notes / Amount of Patient Pays: Per [Name of council on aging agency] notes." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>6. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated, "Amount Insurance Pays: per Medicaid rates / Amount Patient Pays: 0." The "Charge" section was left blank. The The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>7. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive skilled nursing one time a week for 9 weeks, physical therapy, occupational therapy, and home health aide services three times a week for 9 weeks. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was</p>			

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	<p>left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>8. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing services three times a week. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>9. The Administrator, a Registered Nurse, on 09/18/15 at 4:30 PM. The Administrator indicated patient number 2 was receiving Medicare, Medicaid, and Waiver services with the agency. The Administrator was asked and unable to provide any further documentation and / or information regarding the findings.</p> <p>10. An undated policy titled Notification of Financial Responsibility and Non coverage, Home Health Agency Beneficiary Notice (HHABN) indicated, "All clients determined to be eligible for care and service by the Agency will be</p>			

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G 0117 Bldg. 00	<p>informed verbally and in writing regarding any financial responsibility for care and any non covered care or service "</p> <p>484.12 COMPLIANCE W/ FED, STATE, LOCAL LAWS</p> <p>Based on record review and interview, the Agency failed to comply with Indiana State laws and regulation 410 IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients (See G 118) and failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 2 of 4 home visit observations (See G 121).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.12 Compliance with Accepted Professional Standards and Principles.</p>	G 0117	<p>G 117</p> <p>The Administrator has reviewed the agency's policies on Quality Assessment and Performance Improvement Program. The Administrator will ensure that the agency's Quality Assurance Program complies with the Indiana State laws and regulation by ensuring an ongoing quality assurance program that monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The agency will select indicators to monitor that span the scope of the agency's services using tools that include but are not limited to identified or potential problems (observed or reported), patient surveys or questionnaires and incident reports and a final selection made through prioritization. The Administrator has checked to ensure that the indicators being monitored span the scope of the agency's services and that the data collected for September is well documented, monitors and evaluates the quality and</p>	10/14/2015

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			<p>appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>The Supervising Registered Nurse has serviced the Registered Nurses and all field staff on providing care in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Registered Nurse (Employee B) has completed additional services on hand washing, and infection control. The Supervising Registered Nurse has made weekly unannounced visits for 2 weeks to observe Employee B during dressing changes and will make monthly unannounced visits thereafter for 3 quarters to ensure that care is provided in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions."</p>	

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G 0118 Bldg. 00	<p>484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS</p> <p>The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.</p> <p>Based on record review and interview, the Agency failed to comply with Indiana State laws and regulation 410 IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients.</p>	G 0118	<p>The Supervising Registered Nurse has made an unannounced visit and will make monthly unannounced visits for one quarter and quarterly thereafter to observe each field staff providing care, to ensure that care is provided in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>G 118 The Administrator has reviewed the agency's policies on Quality Assessment and Performance Improvement Program. The Administrator will ensure that the agency's Quality Assurance Program complies with the Indiana State laws and regulation by ensuring an ongoing quality assurance program that monitors and evaluates the</p>	10/12/2015	

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	<p>Findings include:</p> <p>1. 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>2. The Administrator provided a quality improvement binder for first and second quarter review on 09/18/15 at 4:45 PM.</p> <p>a. The first quarter compliance percentage included 485 (Plan of Care) signatures at 100%, Dr. orders at 100%, Medical Professionals with signatures at 60%, Communication Letter / 60 day summaries at 100%, Consents with patient signatures at 100%, and Supervisory visits at 100%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>b. The second quarter compliance percentage included 485 signatures at</p>		<p>quality and appropriateness of patient care, resolves identified problems and improves patient care. The agency will select indicators to monitor that span the scope of the agency's services using tools that include but are not limited to identified or potential problems (observed or reported), patient surveys or questionnaires and incident reports and a final selection made through prioritization. The Administrator has checked to ensure that the indicators being monitored span the scope of the agency's services and that the data collected for September is well documented, monitors and evaluates the quality and appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>88%, Dr. orders at 100%, Medical Professions with signatures at 100%, Communication letter / 60 day summaries at 100%, Consents with patient signatures at 100%, Supervisory visits at 100%, Assessments with signatures at 77.7%, and Notes with signature dates at 77.7%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>3. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>4. An undated policy titled Quality Assessment and Performance Improvement Program indicated, " ... Objectives: To maintain and improve the highest quality client care and to reduce or eliminate risks and hazards within the client's environment by: [left blank]; Administering and coordinating the Agency's performance improvement program which is designed to ensure all performance improvement activities are implemented. Identifying and prioritizing opportunities to improve client care using ongoing collection and /</p>			

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	<p>or screening and evaluating information about outcomes of health care and customer satisfaction. Tracking identified problems to ensure improvement or resolution. Developing and implementing effective performance improvement mechanisms such as monitoring and evaluation committees, incident reporting and trending, and client / physician questionnaires. Documenting the findings, conclusions, recommendations, actions taken, and results of actions taken using defined statistical process. Overseeing the effectiveness of the program and detection of trends, patterns of performance or potential problems that may affect more than one office or department. Improving communication among staff and offices when problems or opportunities to improve client care arises. Ensuring performance based credentialing and competency for each professional and paraprofessional caregiver; identifying marginal or substandard performers for enhanced training or termination as appropriate. Evaluating at least annually the scope, organization and effectiveness of the performance improvement program ensuring that actions taken are in pursuit of the objectives of this program and within the mission and goals of the Agency. This evaluation is submitted to</p>			

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	<p>the Board of Director for review, identifying actual, potential client care problems, evaluating the Agency mechanism for addressing client care problems, identifying the need for revisions in client care services, policies and procedures. Evaluating the adequacy of documentation of client care services. Identifying the extent to which the Agency program is adequate, effective, and efficient in use of all manpower and financial resources. Regularly collecting, aggregating, and analyzing data on staff competency. The agency's quality assessment and performance improvement program consists of but is not limited to the following: Program / staff performance assessment activities. Staff recruitment, training, orientation and continuing education programs, case conferences, management meetings, ongoing review of clinical records, clinical staff peer review activities, clinical record / utilization review, clinical staff competency testing program, review of records requested by peer review, management systems that support infection control functions, client / physician / staff satisfaction assessment, performance improvement plans, risk management program, sentinel event action plan, performance control activities, and annual program evaluation.</p>			

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G 0121 Bldg. 00	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 2 of 4 home visit observations. (#1 and 2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An undated policy titled OSHA Regulations / Infection Control / Exposure Control Plan policy indicated, "The agency shall maintain policies and procedures for ... infection control practices by employees which conform with OSHA regulations and currently accepted standards of care " 2. An undated policy titled Bloodborne Pathogens indicated, "Universal precautions will be maintained during the performance of agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves " 3. An undated policy titled Infection 			G 0121	<p>G121The Supervising Registered Nurse has in serviced the RegisteredNurses and all field staff on providing care in accordance with theagency's Infection Control policies and procedures and the Center for Diseaseand Control "Standard Precautions." The Registered Nurse (Employee B) hascompleted additional in services on hand washing, and infection control. The Supervising Registered Nurse has made weekly unannouncedvisits for 2 weeks to observe Employee B during dressing changes and will makemonthly unannounced visits thereafter for 3 quarters to ensure that care isprovide in accordance with the agency's Infection Control policies andprocedures and the Center for Disease and Control "Standard Precautions." TheSupervising Registered Nurse has made an unannounced visit and willmake monthly unannounced visits for one quarter and quarterly thereafter tooobserve each field staff providing care, to ensure that care is providedin accordance with the agency's Infection Control policies and procedures andthe Center for Disease and</p>		10/14/2015

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	<p>Control Program indicated, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives ... To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines "</p> <p>4. The Centers for Disease Control Standard Precautions indicated, "IV. Standard Precautions ... IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves ... IV.F.5. Include</p>		<p>Control "Standard Precautions." The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently ... IV.B. Personal protective equipment (PPE) ... IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin ... could occur. "</p> <p>5. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was observed providing wound care to the patient's left ischium and coccyx wounds. Employee B was observed to don gloves after hand cleaning and remove the patient's soiled dressing, remove gloves and don new gloves, failing to wash hands or use hand sanitizer. Employee B then moistened a 4 x 4 gauze and proceeded to clean the left ischium wound with a Q-tip then moistened another 4 x 4 gauze and proceeded to clean the coccyx wound with a Q-tip, failing to change gloves and clean her hands in between wound sites. Employee B continued to pour saline in a package and cleaned the</p>			

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	<p>left ischium again with Q-tips then took the moistened 4 x 4 gauze and cleaned the patient's groin, then obtained another 4 x 4 gauze and cleaned the coccyx skin area, moving to cleaning the skin around both wounds, failing to change gloves and clean hands between tasks. After the cleaning, Employee B removed her gloves at that time and reapplied gloves without washing hands or sanitizing them. Employee B proceeded to apply santyl ointment (debriding agent that dissolves dead tissue in a wound) to a Q-tip and placed the Q-tip in the wound cavity to apply to dead tissue, then took the same Q-tip and applied more santyl to the tip and placed back in the wound bed, failing to change Q-tips with each application. Employee B continued to obtain another Q-tip and applied santyl to the tip and proceeded to apply ointment to the coccyx wound, failing to change gloves and clean hands between wounds. Employee B then obtained a new Q-tip and applied calmoseptine (skin barrier) to it and proceeded to apply the cream around the edges of the left ischium wound and coccyx wound and well as the surrounding skin, using the same Q-tip, failing to change Q-tips for new area of application. Using the same gloves and Q-tip, Employee B opened another packet of 4 x 4 and placed it in the left ischium and coccyx, then took a roll of</p>			

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	<p>kerlix gauze and cut a strip off the roll and began to pack the left ischium wound then again to the coccyx wound, applied 1 skin prep pap (skin barrier) around the skin, placed an ABD pad over both wounds and secured with tape, failing to change gloves and clean hands between wounds packing of wounds and application of skin treatment. Employee B then removed her gloves and reapplied new gloves and removed a disposable pad from underneath the patient, failing to clean her hands in between glove changes. Employee B then removed her gloves, obtained her blood pressure machine from her nursing bag, and placed the patient's wrist. Employee B returned to her nursing bag and obtained a thermometer and placed it into the patient's mouth, failing to clean hands after gloves removal.</p> <p>6. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was observed providing wound care to patient #2. After doning gloves, Employee B proceeded to clean a wound located to the left outer / lower leg then placed a piece of paper over the wound and traced the wound for measurement. Employee B proceeded to use same piece of paper and traced wounds to the right / lower shin, right / upper shin, right forearm.</p>			

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G 0122 Bldg. 00	<p>Employee B cleaned each wound with a new gauze but failed to change gloves and clean hands between each cleaning. Employee B then began checking for pedal pulses in both feet, removed gloves, don new gloves and applied new dressings to all wounds, without cleaning her hands in between glove changes.</p> <p>7. The Administrator was interviewed on 09/18/15 at 4:30 PM. The Administrator had indicated that she and Employee B had just recently reviewed infection control recently.</p> <p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p> <p>Based on record review and interview, the agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency (See G 123); (A) failed to ensure home health aide had a written competency test in 4 of 4 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015. (B) failed to update a written contract for the provision of a Registered Nurse for 1 of 2 contracts reviewed. (C) failed to ensure agency efforts were coordinated</p>	G 0122	G122 The Administrator has updated the organizational chart to include the names of the employees under the titled positions in the organizational chart. The Administrator has in serviced administrative staff on including the names of the employees under the titled positions in the organizational chart. The administrator will perform quarterly checks and as often as needed with staff changes to ensure that the names of the employees under the titled positions are included in the organizational chart. The Administrator is responsible for	10/12/2015

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	and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (D) failed to ensure the agency complied with Indiana State laws and regulation 410 IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients. (E) failed to ensure a group of professional personnel had annually reviewed the agency's policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation as required creating the potential to affect all of the agency's current 9 patients. (F) failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 4 of 9 records reviewed. (G) failed to ensure the agency informed patients, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 9 of 10 records reviewed. (H) failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide		monitoring this corrective action to ensure that this deficiency is corrected and will not recur. A. The Administrator has ensured that all Home Health Aides employed by the agency have completed the written competency test and that the written competency test and skills tests have been filed timely and appropriately in each Home Health Aide's file. The Administrator has instructed office staff to ensure proper and timely filing of documents in employee files. The Administrator has reviewed the requirements of the Home Health Aide Program with the contractor. The Administrator will ensure that Home Health Aides that are employed by the agency are qualified and competent, have completed the competency evaluation program comprising of the competency skills test and written exam and that the tests are filed timely and appropriately in each Home Health Aide's file. 100% of the Home Health Aide files have been audited to ensure that that there is written documentation maintained in each HHA's files to confirm the completion of the program. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. The Administrator has reviewed agency policies on Performance evaluations for employees to	

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	<p>information to verify that the time requirement was met for 9 of 9 records reviewed. (I)</p> <p>failed to ensure clinical records were complete and current in relation to missing visit notes for 8 of 9 records reviewed (See G 133); failed to ensure test competencies in 4 of 4 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015 (See G 134); failed to update a written contract for the provision of a Registered Nurse for 1 of 2 contracts reviewed (See G 142); failed to ensure their efforts were coordinated effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed (See G 143); failed to ensure their efforts were coordinated and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed (See G 144); and failed to ensure that an effective budgeting and accounting system creating the potential to affect all of the current 9 patients (See G 147).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out</p>		<p>ensure that performance reviews are conducted by the appropriate supervisor on completion of three months of employment, annually thereafter for non-exempt employees and annually for exempt employees. 100% of employee files have been audited to ensure that the 3 month performance reviews for new nonexempt, annually thereafter for non-exempt employees and exempt employees have been performed and documented in their employee files. 100% of employee files will be audited quarterly for 4 quarters to ensure that the 3 month performance reviews for new nonexempt and exempt employees and annually thereafter for non-exempt employees and exempt employees have been performed and documented in their employee files. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. B. The Administrator has updated the written contract for the provision of a Registered Nurse, and reviewed agency policies on contracts to ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates</p>	

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	of compliance with the Condition of Participation 484.314 Organization, Services, and Administration.		contracts to reflect all services provided by the contractor and that all elements of the contract align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that all contracts are updated to accurately reflect all contracted services in all the appropriate sections of the contract and that all elements of the contract align with the agency policy including timeliness of turning in paper work. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. C. Case conferences involving disciplines providing services for patients have been held and documented in the Coordination of care summary, as well as care coordination with outside agencies as ordered in the care plan by the physician and documented in the communication notes. The Administrator has in serviced staff and contractors on the effective coordination of services for all patients by all disciplines providing services and with other outside services, holding case conferences as well as effective documentation of coordinated services in the Coordination of care summary record and making the	

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NAME OF PROVIDER OR SUPPLIER HEALTHSET	STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714
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			documents a part of the patient's clinical record. 100% of patientcharts were audited on 10/10/2015 and will be audited quarterly for 4 quartersto ensure that staff efforts are coordinated and documented effectively withall disciplines providing services and with other outside services that arefurnishing services. The Administrator is responsible for monitoring thiscorrective action to ensure that this deficiency is corrected and will not recur. D. The Administrator has reviewed the agency'spolicies on Quality Assessment and Performance Improvement Program. TheAdministrator will ensure that the agency's Quality Assurance Program complieswith the Indiana State laws and regulation by ensuring an ongoing qualityassurance program that monitors and evaluates the quality and appropriatenessof patient care, resolves identified problems and improves patientcare. The agency will select indicators to monitor that span the scope ofthe agency's services using tools that include but are not limited toidentified or potential problems (observed or reported), patient surveys orquestionnaires and incident reports and a final selection made throughprioritization. The Administrator has checked to ensure that the indicatorsbeing monitored span the scope of the	

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			<p>agency's services and that the data collected for September is well documented, monitors and evaluates the quality and appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. E. The Advisory Committee has reviewed the Agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care clinical records, personnel qualification and program evaluation including the quality improvement program. The Advisory Committee has reviewed the Agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualification and program evaluation including quality</p>	

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			<p>improvement program.</p> <p>The Administrator will monitor bi-annually to ensure that the Advisory committee advises the Agency on professional issues and participates in the Annual evaluation of the Agency program including quality improvement program and documents all proceedings in the minutes. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. F.</p> <p>Admission service agreements have been updated and provided to patients stating disciplines that will furnish care, type of care to be provided, frequency and duration of the proposed visits, as well as verbal explanations to the patients.</p> <p>The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients on admission and as often as needed of the disciplines that will furnish care, type of care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits.</p> <p>100% of patient charts were audited on 10/ 10/2015 and will be audited quarterly for 4 quarters to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, frequency and duration of the</p>	

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			<p>proposed visits, as well as verbal explanations to the patients. TheSupervising Registered Nurse is responsible for monitoring these correctiveactions to ensure that these deficiencies are corrected and will not recur. G.</p> <p>Admission serviceagreements have been updated and provided to patients as well as verbalexplanations stating the charges for services that may not be covered and thatthe individual may have to pay for.</p> <p>TheSupe rvising Registered Nurse has in serviced all Registered Nurses on informingpatients on admission and as often as needed of the charges for services thatmay not be covered and that the individual may have to pay for and specifythese on the Admission Service Agreement in terms that the patient canunderstand as well as verbally. 100%of patient charts will be audited quarterly for evidence that patients were informedof charges for services that may not be covered and that the individual mayhave to pay for and specify these on the Admission Service Agreement in termsthat the patient can understand as well as verbally. The SupervisingRegistered Nurse</p>	

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			<p>is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>H. The Supervising Registered Nurse has in serviced Registered Nurses on ensuring that documentation is written and maintained to verify that the time requirement for completing initial assessment (24-48 hours of referral or discharge from a facility unless otherwise ordered by a physician.) is met by the use of the referral log which will be easily accessible. The Supervising Registered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented with all the referrals, it is maintained by qualified staff and is easily accessible to be used to ascertain that the time requirement has been met for initial assessments. 100% of initial assessment dates will be audited against the referral data in the referral log to ensure that the time requirement for completing assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>I. The Administrator has in serviced healthcare professionals on maintaining the clinical record in such a manner that it is current, assembled and</p>	

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			<p>filed in a timely manner in accordance with law and regulation. 100% of patient charts were audited by 10/06/2015 and will be audited quarterly thereafter to ensure that all is assembled and filed in a timely manner and in accordance with law and regulation. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The Administrator has ensured that all Home Health Aides employed by the agency have completed the written competency test and that the written competency test and skills tests have been filed timely and appropriately in each Home Health Aide's file. The Administrator has serviced office staff to ensure proper and timely filing of documents in employee files. The Administrator has reviewed the requirements of the Home Health Aide Program with the contractor. The Administrator will ensure that Home Health Aides that are employed by the agency are qualified and competent, have completed the competency evaluation program comprising of the competency skills test and written exam and that the tests are filed timely and appropriately in each Home Health Aide's file. 100% of the Home Health Aide files have been audited to ensure that there is written documentation maintained</p>	

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			in each HHA's files to confirm the completion of the program. A monthly audit of 100% of Home Health Aidefiles will be conducted to ensure that each HHA has completed the competencyevaluation program comprising of the competency skills test and writtenexamination and that there is written documentation maintained in each HHA'sfiles to confirm the completion of the program. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is correctedand will not recur. The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performancereviews are conducted by the appropriate supervisor annually for non-exempt and exempt employees. 100% of employee files have been audited to ensure that the annualperformance evaluation for non-exempt and exempt employees have been performedand documented in their employee files. 100% of employee files will be audited quarterly for 4 quarters to ensure that the annual performance reviews for nonexempt and exempt employees have been performed and documented in their employee files. The Administrator is responsible for monitoring these	

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			<p>correctiveactions to ensure that these deficiencies are corrected and will not recur. The Administrator has updated the written contract for the provision of a Registered Nurse and reviewed agency policies on contracts toensure that the agency conducts contract evaluations at least annually and priorto contract renegotiation to identify problems or opportunities forimprovement, updates contracts to reflect all services provided by thecontractor and that all elements of the contract align with the agencypolicies, and determine if contract is to be reviewed or terminated. 100%of contracts have been audited and will be audited quarterly for 4 quarters toensure that all contracts are updated to accurately reflect all contractedservices in all the appropriate sections of the contract and that all elementsof the contract align with the agency policy including timeliness of turning inpaper work The Administrator is responsible for monitoring these correctiveactions to ensure that these deficiencies are corrected and will not recur. Case conferences involving disciplines providing services for patientshave been held and documented in the Coordination of care summary, as well ascare coordination with outside agencies as ordered in the care</p>	

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			<p>plan by the physician and documented in the communication notes. The Administrator has in serviced staff and contractors on the effective coordination of services for all patients by all disciplines providing services and with other outside services, holding case conferences as well as documenting coordinated services in the Coordination of care summary record and making the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that staff efforts are coordinated effectively with all disciplines providing services and with other outside services that are furnishing services.</p> <p>The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. Case conferences involving disciplines providing services for patients have been held and documented in the Coordination of care summary, as well as care coordination with outside agencies as ordered in the care plan by the physician and documented in the communication notes. The Administrator has in serviced staff and contractors on the effective coordination of services for all patients by all disciplines providing services and with other</p>	

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G 0123	484.14 ORGANIZATION, SERVICES &		outside services, holding case conferences as well as effective documentation of coordinated services in the Coordination of care summary record and making the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that staff efforts are coordinated and documented effectively with all disciplines providing services and with other outside services that are furnishing services. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. The Home Health Agency has prepared an overall plan and budget that includes an annual operating budget and capital expenditure plan under the direction of the Board of directors. The Administrator will ensure that they are approved by the Board of Directors by 10/12/2015. The Administrator will monitor bi-annually to ensure that an effective budgeting and accounting systems in place. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.		

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Bldg. 00	<p>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 agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency.</p> <p>Finding included:</p> <ol style="list-style-type: none"> On 9/15/15 at 11:30 AM, the organizational chart was requested. The organizational chart provided indicated titles / positions but failed to include the name of employees under the title / position. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above. A policy titled Administrative Control dated 03/2009, indicated "The Organizational chart defines lines of authority for the delegation of responsibility and accountability down to the patient care level ... " 	G 0123	G123 The Administrator has updated the organizational chart to include the names of the employees under the titled positions in the organizational chart. The Administrator has in serviced administrative staff on including the names of the employees under the titled positions in the organizational chart. The administrator will perform quarterly checks for four quarters and as often as needed with staff changes to ensure that the names of the employees under the titled positions are included in the organizational chart. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	10/01/2015	

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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>A. Based on record review and interview, the Administrator failed to ensure home health aide had a written competency test in 4 of 4 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015. (#C, D, F, G, and I)</p> <p>Findings include:</p> <p>1A. Personnel file C evidenced the individual had been hired on 10/11/12 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2014.</p> <p>2A. Personnel file D was not provided.</p> <p>3A. Personnel file F evidenced the individual had been hired on 08/26/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the</p>	G 0133	<p>G133 A. The Administrator has ensured that all Home Health Aides employed by the agency have completed the written competency test and that the written competency test and skills tests have been filed timely and appropriately in each Home Health Aide's file.</p> <p>The Administrator has in serviced office staff to ensure proper and timely filing of documents in employee files. The Administrator has reviewed the requirements of the Home Health Aide Program with the contractor. The Administrator will ensure that Home Health Aides that are employed by the agency are qualified and competent, have completed the competency evaluation program comprising of the competency skills test and written exam and that the tests are filed timely and appropriately in each Home Health Aide's file. 100% of the Home Health Aide files have been audited to ensure that that there is written documentation maintained in each HHA's files to confirm the completion of the program. A monthly audit of 100% of Home</p>	10/12/2015			

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	<p>employee.</p> <p>4A. Personnel file G evidenced the individual had been hired on 04/21/14 to provided home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2015.</p> <p>5A. Personnel file I evidenced the individual had been hired on 02/09/15 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee.</p> <p>6A. On 09/17/15 at 10:50 AM, employee files were requested to the Administrator. By 12:10 PM, the employee files still were not provided. Upon entering a back office where the Administrator and her Alternate was sitting, Personnel file C was found to be on a table and opened, along with other personnel files on the table. The files were immediately removed from the room. The Administrator had indicated she was making sure that records were complete and correct for review and that loose papers were secured. At 4:30 PM, the Administrator stated Employee D did have a personnel file but she was unable to locate it.</p>		<p>Health Aidefiles will be conducted to ensure that each HHA has completed the competencyevaluation program comprising of the competency skills test and writtenexamination and that there is written documentation maintained in each HHA'sfiles to confirm the completion of the program. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is correctedand will not recur. The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performance reviews are conducted by the appropriate supervisor annually for non-exempt and exempt employees. 100% of employee files have been audited to ensure that the annualperformance evaluation for non-exempt and exempt employees have been performedand documented in their employee files. 100% of employee files will be audited quarterly for 4 quarters toensure that the annual performance reviews for non-exempt and exempt employees have been performed and documented in their employee files. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies arecorrected and will not recur. The Administrator has</p>		

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	<p>7A. An undated policy titled Performance Evaluation indicated, "All non-exempt employees shall be evaluated by the appropriate supervisor upon completion of three (3) months of employment, and annually thereafter. Exempt employees shall be evaluated yearly "</p> <p>8A. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>B. Based on record review and interview, the Administrator failed to update a written contract for the provision of a Registered Nurse for 1 of 2 contracts reviewed.</p> <p>Findings include:</p> <p>1B. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator had stated that clinical visit notes were to</p>		<p>ensured that all contractors actively providing services for the agency have a personnel file and that it is easily accessible. The Administrator will monitor quarterly to ensure that all contractors actively providing services for the agency have a personnel file and that it is easily accessible. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. 7A. The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performance reviews are conducted by the appropriate supervisor upon completion of (3)months of employment and annually thereafter for non-exempt employees and annuallyfor exempt employees. 100% of employee files have been audited to ensure that performance reviews have been conducted by the appropriate supervisor for employees uponcompletion of (3) months of employment and annually thereafter for non-exempt employees and annually for exempt employees and documented in their employeefiles. 100%100% of employee files will be audited quarterly for 4 quarters to ensure that the post3 months evaluation and annual performance reviews for non-exempt and exempt employees have been performed</p>		

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	<p>be in the office within 48 hours following a visit.</p> <p>2B. During a home visit on 09/15/15 at 4:30 PM, Employee D, a Registered Nurse, was observed providing an Intravenous Infusion and assessment to patient #1.</p> <p>3B. Review of Employee D contract dated 07/09/10, the contract indicated Employee D was to provide only Inservice Training and testing of home health aides for home health aide competency evaluation program and consultation. The contract also indicated, "Contractor agrees to submit documentatation of the services provided in accordance with the record keeping requirements of Agency ... on a bi-weekly basis on the MOnday of each pay period week prior to 10:00 AM "</p> <p>4B. The Administrator was interviewed on 09/17/15 at 3:00 PM. The Administrator stated on page 8 of the contract, she had indicated reimbursement for skilled follow up visit and thought that was sufficient to allow Employee D to see patients. The Administrator did not have any further information regarding the timeliness of turning in paperwork.</p>		<p>and documented in their employee files. The Administrator is responsible for monitoring these correctivactions to ensure that these deficiencies are corrected and will notrecur. B. The Administrator has evaluated and updated the written contract for the provision of a Registered Nurse to reflect all the services provided by the contractor and ensure that all elements of the contract align with the agency policies including timeliness of submission of clinicalrecords. The Administrator will ensurethat the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities forimprovement, updates contracts to reflect all services provided by the contractor and that all elements of the contract align with the agencypolicies, and determine if contract is to be reviewed or terminated.100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that contracts have beenevaluated annually, and prior to contract renegotiation to identify problems oropportunities for improvement, and determine if contract is to be reviewedor terminated, that contracts are updated to reflect all services provided bythe contractor and that all elements of the contract align with the agency policies</p>		

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	<p>5B. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6B. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p> <p>7B. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p>		<p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. 5B. The Supervising Registered Nurse has in serviced professional staff on reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days. 100% of patient charts have been audited and will be audited quarterly for four quarters to ensure that care plans are reviewed and updated on an ongoing basis within 5 days of identifying change but no less than every 60 days. The Supervising Registered Nurse is responsible for monitoring the corrective action on care plans to ensure that the deficiency is corrected and will not recur 6B.</p> <p>The Supervising Registered Nurse has in serviced professional staff on the maintenance of clinical records for all patients in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation and agency policies. 100% of charts have been audited will be audited quarterly for four quarters to ensure that notes were written the day of the service delivery and filed in the appropriate chart at least</p>				

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	<p>C. Based on observation, clinical record and policy review and interview, the Administrator failed to ensure agency efforts were coordinated and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1C. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p>		<p>weekly.</p> <p>TheThe Supervising Registered Nurse is responsible for monitoring the corrective action on care plans to ensure that the deficiency is corrected and will not recur. 7B</p> <p>The100% of contracts have been evaluated and the Administrator will continue to ensure that the agency evaluates services at least annually and prior to the contract renegotiation process to identify problems or opportunities for improvement and if the contract is to be revised, renewed or terminated.</p> <p>100% of contracts have been evaluated and will be audited quarterly for 4 quarters to ensure that the agency evaluated services at least annually and prior to the contract renegotiation process to identify problems or opportunities for improvement and if the contract is to be revised, renewed or terminated.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>C. The Administrator has in serviced staff and contractors on</p>				

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	<p>2C. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3C. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also has services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>4C. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide</p>		<p>thecoordination of services for all patients by all disciplines providing servicesand with other outside services furnishing services. All staff providingservices to patient are to participate in the Case conferences and effectivelydocument case conference in the Coordination of care summary and use Communicationnotes to document coordination with outside services furnishing services topatient and make the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will beaudited quarterly for 4 quarters to ensure that agency efforts are coordinated anddocumented effectively in the patient's chart by all disciplines providingservices and with other outside services furnishing services to the patient. The Administrator is responsible for monitoring this correctiveaction to ensure that this deficiency is corrected and will not recur.</p> <p>DThe Administrator has reviewed the agency'spolicies on Quality Assessment and Performance Improvement Program. TheAdministrator will ensure that the agency's Quality Assurance Program complieswith the Indiana State laws and regulation by ensuring an ongoing qualityassurance program that monitors and evaluates the</p>		

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	<p>services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5C. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6C. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and</p>		<p>quality and appropriateness of patient care, resolves identified problems and improves patient care. The agency will select indicators to monitor that span the scope of the agency's services using tools that include but are not limited to identified or potential problems (observed or reported), patient surveys or questionnaires and incident reports and a final selection made through prioritization. The Administrator has checked to ensure that the indicators being monitored span the scope of the agency's services and that the data collected for September is well documented, monitors and evaluates the quality and appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>E The Advisory Committee has reviewed the Agency policies governing the scope of services offered, admission and</p>		

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	<p>occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7C. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8C. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9C. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10C. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11C. An undated policy titled</p>		<p>discharge policies, medical supervision and plans oftreatment, emergency care clinical records, personnel qualification and programevaluation including quality improvement program. The Administrator willmonitor bi-annually to ensure that the Advisory committee advises the Agency onprofessional issues and participates in the Annual evaluation of the Agencyprogram including quality improvement program and documents all proceedings inthe minutes.The Administrator isresponsible for monitoring these corrective actions to ensure that thesedeficiencies are corrected and will not recur. FThe SupervisingRegistered Nurse has in serviced all Registered Nurses on informing patients ofthe disciplines that will furnish care, type of care to be furnished, changesin the care to be furnished, frequency and duration of the proposed visits andspecify these on the admission Service Agreement in terms that the patient canunderstand.Admission serviceagreements have been updated and provided to patients stating disciplines thatwill furnish care, type of care to be provided, frequency and duration of theproposed visits, as well as verbal explanations to the patients. 100% of patientcharts will be audited quarterly for</p>		

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	<p>Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>D. Based on record review and interview, the Administrator failed to ensure the agency complied with Indiana State laws and regulation 410 IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients.</p> <p>Findings include:</p> <p>1D. 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>2D. The Administrator provided a quality improvement binder for first and second quarter review on 09/18/15 at</p>		<p>evidence that patients were informed of the care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits and specify these on the Admission Service Agreement in terms that the patient can understand. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. G. The Supervising Registered Nurse has in serviced professional staff on notifying patients on admission and as often as necessary, verbally and in writing the charges for services, client and agency responsibilities for care and any financial responsibilities including the cost of care and charges for services that may not be covered and that the individual may have to pay for. Admission service agreements have been updated and provided to patients stating the charges for services, client and agency responsibilities for care and any financial responsibilities including the cost of care and charges for services that may not be covered and that the individual may have to pay for as well as verbal explanations to the patients. 100% of patient charts will be audited quarterly for evidence that patients were informed of the charges for services, client and agency</p>		

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	<p>4:45 PM.</p> <p>a. The first quarter compliance percentage included 485 (Plan of Care) signatures at 100%, Dr. orders at 100%, Medical Professionals with signatures at 60%, Communication Letter / 60 day summaries at 100%, Consents with patient signatures at 100%, and Supervisory visits at 100%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>b. The second quarter compliance percentage included 485 signatures at 88%, Dr. orders at 100%, Medical Professions with signatures at 100%, Communication letter / 60 day summaries at 100%, Consents with patient signatures at 100%, Supervisory visits at 100%, Assessments with signatures at 77.7%, and Notes with signature dates at 77.7%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>3D. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable</p>		<p>responsibilities for care and any financial responsibilities including the cost of care and charges for services that may not be covered and that the individual may have to pay for. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. HThe Supervising Registered Nurse has in serviced Registered Nurses on ensuring that documentation is written and maintained to verify that the time requirement for completing initial assessment (24-48 hours of referral or discharge from a facility unless otherwise ordered by a physician.) is met by the use of the referral log. which will be easily accessible. The Supervising Registered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented with all the referrals, it is maintained by qualified staff and is easily accessible to be used to ascertain that the time requirement has been met for initial assessments. 100% of initial assessment dates will be audited against the referral data in the referral log to ensure that the time requirement for completing assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that</p>		

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	<p>to provide any further documentation and / or information regarding the findings referenced above.</p> <p>4D. An undated policy titled Quality Assessment and Performance Improvement Program indicated, " ... Objectives: To maintain and improve the highest quality client care and to reduce or eliminate risks and hazards within the client's environment by: [left blank]; Administering and coordinating the Agency's performance improvement program which is designed to ensure all performance improvement activities are implemented. Identifying and prioritizing opportunities to improve client care using ongoing collection and / or screening and evaluating information about outcomes of health care and customer satisfaction. Tracking identified problems to ensure improvement or resolution. Developing and implementing effective performance improvement mechanisms such as monitoring and evaluation committees, incident reporting and trending, and client / physician questionnaires. Documenting the findings, conclusions, recommendations, actions taken, and results of actions taken using defined statistical process. Overseeing the effectiveness of the program and detection of trends, patterns of</p>		<p>these deficiencies are corrected and will not recur.</p> <p>TheThe Administrator has in serviced healthcare professionals on maintaining theclinical record in such a manner that it is current, assembled and filed in atimely manner in accordance with law and regulation. 100% of patient chartswere audited by 10/06/2015 and will be audited quarterly thereafter to ensurethat all documents are assembled and filed in a timely manner and in accordance with lawand regulation.</p> <p>The Administrator is responsible for monitoring these corrective actionsto ensure that these deficiencies are corrected and will not recur</p>	

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	<p>performance or potential problems that may affect more than one office or department. Improving communication among staff and offices when problems or opportunities to improve client care arises. Ensuring performance based credentialing and competency for each professional and paraprofessional caregiver; identifying marginal or substandard performers for enhanced training or termination as appropriate. Evaluating at least annually the scope, organization and effectiveness of the performance improvement program ensuring that actions taken are in pursuit of the objectives of this program and within the mission and goals of the Agency. This evaluation is submitted to the Board of Director for review, identifying actual, potential client care problems, evaluating the Agency mechanism for addressing client care problems, identifying the need for revisions in client care services, policies and procedures. Evaluating the adequacy of documentation of client care services. Identifying the extent to which the Agency program is adequate, effective, and efficient in use of all manpower and financial resources. Regularly collecting, aggregating, and analyzing data on staff competency. The agency's quality assessment and performance improvement program consists of but is</p>			

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	<p>not limited to the following: Program / staff performance assessment activities. Staff recruitment, training, orientation and continuing education programs, case conferences, management meetings, ongoing review of clinical records, clinical staff peer review activities, clinical record / utilization review, clinical staff competency testing program, review of records requested by peer review, management systems that support infection control functions, client / physician / staff satisfaction assessment, performance improvement plans, risk management program, sentinel event action plan, performance control activities, and annual program evaluation.</p> <p>E. Based on record review and interview, the Administrator failed to ensure a group of professional personnel had annually reviewed the agency's policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation as required creating the potential to affect all of the agency's current 9 patients.</p> <p>Findings include:</p> <p>1E. The agency's administrative records included an "Advisory Committee Meeting" minutes dated 02/13/15. The</p>			

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	<p>attendance included a Registered Nurse, Community Member, and Administrator. The minutes indicated [name of Physician] had an "excused absence." Topics discussed were 2014 Annual Report, stalemate in the census, advertising, Quality Improvement Program, and staff retention. The Advisory Committee failed to evidence and discuss Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification and program evaluation. The minutes failed to evidence quality improvement program issues and interventions.</p> <p>2E. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>3E. An undated policy titled Organizational Guidelines indicated, " ... Duties of the Advisory Committee: The Advisory Committee shall: Establish and annually review the Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical</p>			

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	<p>records, and personnel qualification and program evaluation, Advise the Agency on professionals issues, Participate in the annual evaluation of the Agency's program "</p> <p>F. Based on record review and interview, the Administrator failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 4 of 9 records reviewed. (#2, 7, 8, and 9)</p> <p>Findings include:</p> <p>1F. Clinical record #2, SOC (start of care) 12/15/14. The Admission Service Agreement dated 12/15/14, indicated the patient was to receive home health aide services for bathing and ADLs (activities of daily living). The Admission Service Agreement failed to evidence the frequency of the proposed visits.</p> <p>2F. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive home health aide services three times a week and homemaker services two times a week. The "Planned Treatment" was left blank. The Admission Service Agreement failed to</p>			

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	<p>evidence the scope of services that was to be provided by the home health aide and homemaker. The Admission Service Agreement failed to evidence the length of services to be provided.</p> <p>3F. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive physical therapy and occupational therapy. The Admission Service Agreement failed to evidence the frequency proposed and plan of treatment for physical and occupational therapy.</p> <p>4F. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing three times a week for "assessment, medication administration per 485." The Admission Service Agreement failed to specify in terms that the patient can understand (485) for planned treatment and failed to specify duration of services to be provided.</p> <p>5F. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>6F. An undated policy titled Client</p>			

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	<p>Rights indicated, " ... The client has the right to be informed about the care to be furnished, and of any changes in the care to be furnished ... "</p> <p>7F. An undated policy titled Informed Consent indicated, "An informed consent will be explained to and signed by all clients or the client's legal representative prior to admission. Explanation of the informed consent ensures that all client / families are informed about the type of care and services provided during the course of illness and that the client / family consent to such ... "</p> <p>8F. An undated policy titled Client Rights / Responsibilities indicated, " ... On admission and as often as necessary, verbally and in writing, client and Agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to the care / services provided by the Agency will be provided to the client / caregiver(s) ... "</p> <p>G. Based on clinical record review and interview, the Administrator failed to ensure the agency informed patients, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 9 of</p>			

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	<p>10 records reviewed. (#1 - 4, 6 - 9)</p> <p>Findings include:</p> <p>1G. Clinical record number 1, SOC (start of care) 11/27/13. The Admission Service Agreement dated 11/27/13, indicated "Charge: 0." The Amount Insurance pays and the amount the patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>2G. Clinical record #2, SOC date 12/15/14. During a home visit on 09/16/15 at 08:00 AM, the patient had stated that she did not know if the services she was receiving was under Medicare, Medicaid, and / or Waiver services. The Admission Service Agreement dated 11/27/13, the Charge section, amount insurance pays, and amount patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>3G. Clinical record #3, SOC date 06/24/15. The Admission Service Agreement dated 06/24/15, indicated "Charge: 0 / Amount Insurance Pays:</p>			

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	<p>Medicare rate / Amount patient pays: 0." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>4G. Clinical record #4, SOC 09/24/14. The Admission Service Agreement dated 09/24/14, indicated "Charge: 0 / Amount Insurance Pays: Per Medicaid Notes / Amount Patient Pays: Per spenddown if applicable." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>5G. Clinical record #6, SOC 02/13/14. The Admission Service Agreement dated 02/13/14, indicated "Charge: 0 / Amount Insurance Pays: Per [Name of council on aging agency] notes / Amount of Patient Pays: Per [Name of council on aging agency] notes." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>6G. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated, "Amount Insurance Pays: per Medicaid rates / Amount Patient Pays: 0." The "Charge" section was left blank. The The Admission Service Agreement failed to evidence</p>			

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	<p>charges that may occur for services not covered by the insurance benefit.</p> <p>7G. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive skilled nursing one time a week for 9 weeks, physical therapy, occupational therapy, and home health aide services three times a week for 9 weeks. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>8G. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing services three times a week. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>9G. The Administrator, a Registered Nurse, on 09/18/15 at 4:30 PM. The</p>			

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	<p>Administrator indicated patient number 2 was receiving Medicare, Medicaid, and Waiver services with the agency. The Administrator was asked and unable to provide any further documentation and / or information regarding the findings.</p> <p>10G. An undated policy titled Notification of Financial Responsibility and Non coverage, Home Health Agency Beneficiary Notice (HHABN) indicated, "All clients determined to be eligible for care and service by the Agency will be informed verbally and in writing regarding any financial responsibility for care and any non covered care or service "</p> <p>1H. Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p> <p>Findings include:</p> <p>1H. Patient record #1, SOC (start of care) 11/27/13. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information</p>			

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	<p>to verify that the time requirement was met.</p> <p>2H. Patient record #2, SOC 12/15/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>3H. Patient record #3, SOC 06/24/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>4H. Patient record #4, SOC 09/24/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>5H. Patient record #5, SOC 09/25/12. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>6H. Patient record #6, SOC 02/13/14. The clinical failed to ensure initial assessments were completed within 48</p>			

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	<p>hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>7H. Patient record #7, SOC 01/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>8H. Patient record #8, SOC 07/30/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>9H. Patient record #9, SOC 04/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>10H. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11H. An undated policy titled Referral and Acceptance of Clients indicated, "The Agency shall have procedures for</p>			

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	<p>the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained ... Clients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility unless otherwise ordered by the physician ... "</p> <p>I. Based on record review and interview, the agency failed to ensure clinical records were complete and current in relation to missing visit notes for 8 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, 8, and 9).</p> <p>Findings include:</p> <p>1I. Clinical record #2, SOC 12/15/14, failed to evidence home health aide visit notes after 09/09/15 and skilled nursing visit notes after 09/11/15.</p> <p>2I. Clinical record #3, SOC 06/24/15, failed to evidence home health aide visit notes after 09/11/5, physical therapy notes after 09/02/15 and occupational therapy notes after 09/04/15.</p> <p>3I. Clinical record #4, SOC 09/29/14, failed to evidence home health aide visit</p>			

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	<p>notes 09/07/15.</p> <p>4I. Clinical record #5, SOC 09/25/14, failed to evidence home health aide visit notes after 09/05/15.</p> <p>5I. Clinical record #6, SOC 02/13/14, failed to evidence home health aide visit notes after 09/08/15.</p> <p>6I. Clinical record #7, SOC 01/13/15, failed to evidence home health aide visit notes after 09/03/15.</p> <p>7I. Clinical record #8, SOC 07/30/15, failed to evidence attendant care visit notes after 08/17/15.</p> <p>8I. Clinical record #9, SOC 04/03/15, failed to evidence skilled nursing visit notes after 09/09/15.</p> <p>9I. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator stated that the time frame allowed for clinicians to turn in documentation following a visit was 48 hours and 7 days for documents to be filed in the patient records.</p> <p>10I. After the entrance conference on 09/15/15 at 12:00 PM, the Administrator was instructed to provide all patient records at once for review. At 12:20 PM,</p>			

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	<p>only one record had been provided. The Administrator was observed taking a record to the front reception desk area. At 1:15 PM, the Administrator was interviewed on reason for delay of clinical records. The Administrator stated that she was making sure the charts were complete due to her office manager had quit the previous week and she was behind on filing. On 09/18/15 at 2:00 PM, the Administrator was given the opportunity to provide any missing documentation to the surveyor that was not in the patients record.</p> <p>11I. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p> <p>J. An undated policy titled Administrative Staff indicated, " ... The Administrator's duties shall include but not be limited to the following: Organizes and directs the agency's ongoing functions. Maintains liasion</p>			

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G 0134 Bldg. 00	<p>among the Board of Directors, Advisory Committee, and staff. Employs qualified personnel and ensures appropriate staff education and evaluation ... Implements an effective budget and accounting system ... Ensures that the Agency is in compliance with all federal, state, and local regulations related to the delivery of home health care.</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on record review and interview, the Administrator failed to ensure test competencies in 4 of 4 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015. (#C, D, F, G, and I)</p> <p>Findings include:</p> <p>1. Personnel file C evidenced the individual had been hired on 10/11/12 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2014.</p>			G 0134	<p>G 134 The Administrator has ensured that all HomeHealth Aides employed by the agency have completed the written competency test and that the written competency test and skills tests have been filed timely and appropriately in each Home Health Aide's file. The Administrator has in serviced office staff to ensure proper and timely filing of documents in employee files. The Administrator has reviewed the requirements of the Home Health Aide Program with the contractor. The Administrator will ensure that Home Health Aides that are employed by the agency are qualified and competent, have completed the competency</p>		10/12/2015

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	<p>2. Personnel file D was not provided.</p> <p>3. Personnel file F evidenced the individual had been hired on 08/26/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee.</p> <p>4. Personnel file G evidenced the individual had been hired on 04/21/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2015.</p> <p>5. Personnel file I evidenced the individual had been hired on 02/09/15 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee.</p> <p>6. On 09/17/15 at 10:50 AM, employee files were requested to the Administrator. By 12:10 PM, the employee files still were not provided. Upon entering a back office where the Administrator and her Alternate was sitting, Personnel file C was found to be on a table and opened, along with other personnel files on the table. The files were immediately removed from the room. The</p>		<p>evaluation program comprising of the competency skills test and written exam and that the tests are filed timely and appropriately in each Home Health Aide's file.</p> <p>100% of the Home Health Aide files have been audited to ensure that there is written documentation maintained in each HHA's files to confirm the completion of the program.</p> <p>A monthly audit of 100% of Home Health Aide files will be conducted to ensure that each HHA has completed the competency evaluation program comprising of the competency skills test and written examination and that there is written documentation maintained in each HHA's files to confirm the completion of the program.</p> <p>The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performance reviews are conducted by the appropriate supervisor upon completion of (3) months of employment and annually thereafter for non-exempt employees and annually for exempt employees.</p> <p>100% of employee files have been audited to ensure that performance reviews have been conducted by the appropriate supervisor for employees</p>		

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	<p>Administrator had indicated she was making sure that records were complete and correct for review and that loose papers were secured. At 4:30 PM, the Administrator stated Employee D did have a personnel file but she was unable to locate it.</p> <p>7. An undated policy titled Performance Evaluation indicated, "All non-exempt employees shall be evaluated by the appropriate supervisor upon completion of three (3) months of employment, and annually thereafter. Exempt employees shall be evaluated yearly "</p> <p>8. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p>		<p>upon completion of (3) months of employment and annually thereafter for non-exempt employees and annually for exempt employees and documented in their employee files.</p> <p>100% of employee files will be audited quarterly for 4 quarters to ensure that the post 3 months evaluation and annual performance reviews for nonexempt and exempt employees have been performed and documented in their employee files. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>The Administrator will ensure that the agency evaluates services at least annually and prior to the contract renegotiation process to identify problems or opportunities for improvement and if the contract is to be revised, renewed or terminated.</p> <p>100% of contracts have been evaluated and will be audited quarterly for 4 quarters to ensure that the agency evaluated services at least annually and prior to the contract renegotiation process to identify problems or</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 0142 Bldg. 00	<p>484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT</p> <p>If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following:</p> <p>(1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.</p> <p>Based on record review and interview, the Administrator failed to update a written contract for the provision of a Registered Nurse for 1 of 2 contracts reviewed.</p>	G 0142	<p>opportunities for improvement and if the contract is to be revised, renewed or terminated.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>G142 The Administrator has evaluated and updated the written contract for the provision of a Registered Nurse to reflect all the services provided by the contractor and ensure that all elements of the contract align with</p>	10/10/2015	

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator had stated that clinical visit notes were to be in the office within 48 hours following a visit. 2. During a home visit on 09/15/15 at 4:30 PM, Employee D, a Registered Nurse, was observed providing an Intravenous Infusion and assessment to patient #1. 3. Review of Employee D contract dated 07/09/10, the contract indicated Employee D was to provide only Inservice Training and testing of home health aides for home health aide competency evaluation program and consultation. The contract also indicated, "Contractor agrees to submit documentation of the services provided in accordance with the record keeping requirements of Agency ... on a bi-weekly basis on the MOnday of each pay period week prior to 10:00 AM " 4. The Administrator was interviewed on 09/17/15 at 3:00 PM. The Administrator stated on page 8 of the contract, she had indicated reimbursement for skilled follow up visit and thought that was sufficient to allow Employee D to see 		<p>the agency policies including timeliness of submission of clinical records. The Administrator will ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates contracts to reflect all services provided by the contractor and that all elements of the contract align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that contracts have been evaluated annually, and prior to contract renegotiation to identify problems or opportunities for improvement, and determine if contract is to be reviewed or terminated, that contracts are updated to reflect all services provided by the contractor and that all elements of the contract align with the agency policies.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The Administrator has in service healthcare professionals on maintaining the clinical record in such a manner that it is current, assembled and filed in a timely manner in accordance with law</p>		

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	<p>patients. The Administrator did not have any further information regarding the timeliness of turning in paperwork.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p> <p>7. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be</p>		<p>and regulation. 100% of patient charts were audited by 10/06/2015 and will be audited quarterly thereafter to ensure that all is assembled and filed in a timely manner and in accordance with law and regulation.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>The Administrator has evaluated and updated the written contract for the provision of a Registered Nurse to reflect all the services provided by the contractor and ensure that all elements of the contract align with the agency policies including timeliness of submission of clinical records. The Administrator will ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates contracts to reflect all services provided by the contractor and that all elements of the contract align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that contracts have been evaluated annually, and prior to contract renegotiation to identify problems or</p>	

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G 0143 Bldg. 00	<p>revised, renewed or terminated "</p> <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. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to</p>	G 0143	<p>opportunities for improvement, and determine if contract is to be reviewed or terminated, that contracts are updated to reflect all services provided by the contractor and that all elements of the contract align with the agency policies.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>G143 The Administrator has in serviced staff and contractors on the coordination of services for all patients by and between all disciplines providing services and with other outside services holding case conferences as well as effective documentation of coordinated services in the patient's clinical record using Coordination of care summary form for case conference and communication note for care coordination with outside agencies. 100% of patient charts were audited on 10/ 10/2015 and will be audited quarterly for 4 quarters to ensure that all disciplines providing patient with service coordinate care and</p>	10/10/2015

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	<p>the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record</p>		<p>document such coordination in the clinical record, Coordination of care summary for case conference and communication note for coordination with outside agencies. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was</p>			

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	<p>attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on</p>			

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	<p>09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>12. An undated policy titled Coordination of Care indicated, "The agency shall coordinate the care of all patients under the agency's services. All personnel providing services to patients shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The method of communication and results shall be documented in the clinical record and or coordination of care summary</p>			

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G 0144 Bldg. 00	<p>record during case conferences. The records shall be a part of the clinical record. The agency shall coordinate its services with other health providers serving the patient."</p> <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. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence</p>	G 0144	G144 The Administrator has in serviced staff and contractors on the coordination of services for all patients by and between all disciplines providing services and with other outside services via regularly held case conferences as well as effective documentation of coordinated services in the coordination of care summary form for case conferences and communication note for care coordination with outside services furnishing patient with care and making them a part of the patient's clinical record. 100% of patient charts were audited on 10/ 10/2015 and will be audited quarterly for 4 quarters to ensure that using case conferences as well as effective documentation of coordination of services, services werecoordinated for all patients by all disciplines providing services and with other outside services and documented in the patient's chart. The Administrator is responsible for	10/10/2015

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	<p>coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also has services with a council on aging agency and care coordination was to be done every 60 days. The</p>		<p>monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p>			

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	<p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing</p>			

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G 0147 Bldg. 00	<p>services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>12. An undated policy titled Case Conferencing indicated, " ... Case conferences shall be held regularly to review problem cases and to review the plan of treatment for appropriateness and feasibility of continued services. Such conferences shall be documented separately or in the clinical record and should be held on each client at the time of admission, prior to the date of the plan of treatment is due for the review and prior to discharge "</p> <p>484.14(i) INSTITUTIONAL PLANNING The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan.</p>			

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	<p>(1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense.</p> <p>(2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than \$600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds \$600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting,</p>			

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	<p>and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.</p> <p>(ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following:</p> <p>(A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.</p> <p>(B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations.</p> <p>(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.</p> <p>Based on record review and interview, the agency failed to ensure that an effective budgeting and accounting system creating the potential to affect all of the current 9 patient patients.</p> <p>Findings include:</p> <p>1. On 09/17/15 at 10:00 AM, the Administrator was requested to provide the Annual Operating Budget and Capital</p>	G 0147	<p>G 147</p> <p>G147 The Home Health Agency has prepared an overall plan and budget that includes an annual operating budget and capital expenditure plan under the direction of the Board of directors. The Administrator will ensure that they are approved by the Board of Directors by 10/12/2015. The Administrator will monitor bi-annually to ensure that the Home Health Agency has an effective budgeting and</p>	10/12/2015

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G 0153 Bldg. 00	<p>Expenditure Plan for 2015. At 11:15 AM, the Administrator provided a Profit and Loss Budget Overview for 2014. The Administrator failed to provide an effective budgeting and accounting system.</p> <p>2. An undated policy titled Committees indicated, " ... Budget Committee ... prepares the Agency's annual budget and reviews the financial position of the Agency "</p> <p>3. An undated policy titled Administrative Staff, " ... The Administrator's duties shall include but not be limited to the following ... Implements an effective budget and accounting system ... "</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on record review and interview, the agency failed to ensure a group of professional personnel had annually reviewed the agency's policies, medical</p>	G 0153	<p>accounting system is in place. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p> <p>G 153 G 153 All members of the Advisory Committee participated in reviewing the Agency policies governing the scope of services offered, admission and discharge</p>	09/28/2015			

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	<p>supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation as required creating the potential to affect all of the agency's current 9 patients..</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records included an "Advisory Committee Meeting" minutes dated 02/13/15. The attendance included a Registered Nurse, Community Member, and Administrator. The minutes indicated [name of Physician] had an "excused absence." Topics discussed were 2014 Annual Report, stalemate in the census, advertising, Quality Improvement Program, and staff retention. The Advisory Committee failed to evidence and discuss Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification and program evaluation. The minutes failed to evidence quality improvement program issues and interventions. 2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in 		<p>policies, medical supervision and plans of treatment, emergency care clinical records, personnel qualification and program evaluation including quality improvement program on 09/28/2015. The Administrator will monitor bi-annually to ensure that the Advisory committee advises the Agency on professional issues and participates in the Annual evaluation of the Agency program including quality improvement program and documents all proceedings in the minutes. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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G 0158 Bldg. 00	<p>the records referenced above.</p> <p>3. An undated policy titled Organizational Guidelines indicated, " ... Duties of the Advisory Committee: The Advisory Committee shall: Establish and annually review the Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification and program evaluation, Advise the Agency on professionals issues, Participate in the annual evaluation of the Agency's program "</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and policy review and interview, the agency failed to ensure visits had been provided and nursing assessments provided only as ordered by the physician per plan of care in 9 of 10 records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care)</p>	G 0158	G 158 The Supervising Registered Nurse has in serviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited and visits had been provided and nursing assessments provided only as ordered by the physician. 100% of the patient's charts will be audited monthly for two months	10/12/2015

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	<p>11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15, with orders for skilled nursing visits were to be provided two times a week for 9 weeks. Review of the skilled nursing visit notes, the record failed to evidence a second visit during week one, two, three, four, six, seven, and eight. The skilled nurse failed to follow the plan of care.</p> <p>2. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing visits to be provided two time a week for one week, three times a week for one week, four times a week for one week, three times a week for four weeks, four times a week for one week, and three times a week for one week. Review of the skilled nursing visit notes on 09/15/15 at 1:30 PM, the record failed to evidence a fourth visit during week three. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record #3, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks.</p>		andquarterly thereafter to ensure that care provided is consistent with the planof care established by the physician, and that visits are provided and nursingassessments provided only as ordered by the physician. The Supervising Registered Nurse is responsible for monitoringthese corrective actions to ensure that these deficiencies are corrected andwill not recur				

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	<p>a. During a home visit on 09/16/15 at 8:00 AM, the patient had stated that the agency sometimes have problems staffing home health aides for both times of the day. The patient stated getting her two visits in would depend on what home health aide was working on that particular day.</p> <p>b. Review of the home health aide visit notes on 09/15/15 at 2:45 PM, the record failed to evidence a second visit was made on 08/31/15 to 09/02/15 and 08/07/15 to 09/09/15. The home health aide failed to follow the plan of care.</p> <p>c. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>4. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing one time every other week for 8 weeks for supervision, case management, assessment and home health aide services 7 days a week for 8 weeks then four days a week for one week.</p> <p>a. Review of the skilled nursing notes failed to evidence nursing</p>			

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	<p>assessments and case management every other week. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period on 07/27, 07/28, 07/30, 08/04, 08/06, 08/07, 08/13, 08/18, 08/20, 08/21, 08/23, 08/25, 09/01, 09/23/15. The record also failed to evidence that a home health aide visit was made on 08/29/15. The home health aide failed to follow the plan of care.</p> <p>c. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>5. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services four times a week for two weeks then two times a week for one week.</p> <p>a. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period, twice a week during week 1, 2, 3, 4, 5, 6, 8, and made two visits on 08/25/15 during week 7. The home health aide failed to follow the plan of care.</p>			

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	<p>b. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>6. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing one every two weeks for 8 weeks then one time a week for one week for recertification and attendant care services one time a week for one week, 5 times a week for 8 weeks, then one time a week for one week.</p> <p>a. The plan of care indicated the skilled nurse was to assess cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p> <p>b. A signed physician order dated 08/20/15, indicated to discontinue attendant care services and to start home health aide services two times a week for one week, 5 times a week for 6 weeks, then one time a week for one week. Review of the attendant care and home health aide visit notes, the attendant care</p>			

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	<p>continued to see the patient on 08/22 and 08/23/15. The home health aide made his / her first visit on 08/24/15. The attendant care and home health aide failed to follow the plan of care.</p> <p>c. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>7. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing one time every two weeks for 8 weeks, home health aide services three times a week for 8 weeks then two times a week for one week and homemaker services two times a week for 9 weeks.</p> <p>a. Review of the plan of care indicated the skilled nurse was to assess the cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p>			

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	<p>b. Review of the home health aide visit notes, the clinical record failed to evidence that visits were made between 07/12/15 to 08/17/15. The home health aide failed to follow the plan of care.</p> <p>c. Review of the homemaker visit notes, the clinical record evidenced that two extra visits (total of 4 visits) were made between 08/25/15 to 08/28/15. The homemaker failed to follow the plan of care.</p> <p>8. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing one time a week for one week, two times a week for one week, then one times a week for 7 weeks, home health aide services one time a week for one week then three times a week for 8 weeks, occupational therapy one time a week for one week, two times a week for two weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the clinical record failed to evidence that a second visit was provided during week two. The skilled nurse failed to follow the plan of care.</p>			

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	<p>b. Review of the home health aide visit notes, the clinical record failed to evidence that two visits were made during week two. The home health aide failed to follow the plan of care.</p> <p>c. Review of the occupational therapy notes, the clinical record failed to evidence that two visits were made during week two. The occupational therapist failed to follow the plan of care.</p> <p>d. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued and homemaker services would start the week of 08/09/15, three times a week for 7 weeks. Review of the homemaker visit notes, the clinical record failed to evidence that two visits were made during week 5, three visits were made during week 6, one visit was made during week 7, and three visits were made during week 8. The homemaker failed to follow the plan of care.</p> <p>9. Clinical record #9, SOC 04/13/15, included a plan of care established by the physician for the certification period 08/01/15 to 09/29/15 with orders for skilled nursing four times a week for 8 weeks then two times a week for 1 one starting the week of 08/02/15. Review of the skilled nursing visit notes, the clinical</p>			

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G 0159 Bldg. 00	<p>record failed to evidence a fourth visit was made during week two and three visits were made during week three. The skilled nurse failed to follow the plan of care.</p> <p>10. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The Agency will provide care / services consistent with the plan of care ... "</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 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. Based on observation, clinical record and policy review and interview, the agency failed to ensure plans of care were revised that included all medications for</p>	G 0159	G 159 The Supervising Registered Nurse has in serviced staff on reviewing care plans on an ongoing basis but no less often than 60 days and updating	10/12/2015

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	<p>3 of 9 records reviewed. (#1, 2, and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15.</p> <p>a. Line 21 (Orders for Discipline and Treatments) of the Plan of care indicated the patient was to receive Benedryl 25 mg (milligrams) via g/tube (gastrostomy tube) 30 to 60 minutes prior to infusion, Emla cream or LMX4 (numbing agent) cream one hour prior to accessing port, infuse Elaprase 24 mg via port a cath [catheter] once a week, dilute Elaprase in 0.9 Sodium chloride in 100 ml (milliliter) bag, flush IV [intravenous] line with normal saline and heparin, give Epinephrine 0.01 mg per kilogram for severe reaction to medication. The Medication profile failed to indicate the medications listed and the strength of the normal saline and heparin flushes.</p> <p>b. Line 21 also indicated "SN [skilled nurse] to follow all medication protocol per [Name of Pharmacy]. The plan of care failed to indicate what the medication protocol specific to the medication was.</p>		<p>the care plan to reflect the change, include but not limit care plan to specific discipline, frequency and duration of services, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. 100% of patient charts were audited on 10/12/2015 to ensure that care plans have been reviewed and updated and were found to be in compliance. 80% of patient charts will be audited monthly for two months and quarterly thereafter for three quarters to ensure that care plans have been reviewed and updated no less often than 60 days and that care plans include but are not limited to specific discipline, frequency and duration of service, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>2. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks. The plan of care failed to be updated and specific to include the the amount of visits per day and the length of time per visit specific to the payer source.</p> <p>a. Review of the recertification follow up assessment dated 08/27/15, indicated the registered nurse had been applying nystatin cream to the reddened areas in the patient's abdominal folds. The medication section of the plan of care failed to include the nystatin cream, strength, and instructions.</p> <p>b. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. The plan of care failed to include coordination of services with the wound center.</p> <p>3. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Two recertification / follow up assessments dated 07/10/15 and 09/08/15, indicated the patient was receiving IV infusions</p>			

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	<p>twice a week from an outside agency. The plan of care failed to be updated to include the IV medication and failed to be updated to include that the patient was receiving skilled nursing, physical and occupational therapy from an outside agency.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The plan of care shall include but not be limited to ... Specific discipline, frequency and duration of services ... Medications ... Orders for treatments ... The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment "</p>			

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G 0168 Bldg. 00	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and policy review and interview, skilled nursing failed to ensure visits, assessments, and care coordination was provided per the plan of care 9 of 9 records reviewed (See G 170); failed to ensure plans of care were revised that included all medications for 3 of 9 records reviewed (See G 173); failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 2 of 4 home visit observations (See G 174); and failed to ensure their efforts were coordinated and documented effectively with all discipline providing services and with other outside services that were furnishing services for 7 of 9 records reviewed (See G 176).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Nursing Service.</p>			G 0168	<p>G 168 100% of patient charts were audited on 10/12/2015 to ensure that care plans have been reviewed and updated to include all medications and were found to be in compliance. 80% of patient charts will be audited monthly for two months and quarterly thereafter for three quarters to ensure that care plans have been reviewed and updated no less often than 60 days and that care plans include but are not limited to specific discipline, frequency and duration of service, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse has inserviced the Registered Nurses and all field staff on providing care in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Registered Nurse (Employee B) has completed additional in services on hand washing, and infection control. The Supervising Registered Nurse has made weekly unannounced visits for 2 weeks to observe Employee B during dressing changes and will make monthly unannounced visits thereafter for 3 quarters to ensure</p>		10/12/2015

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			<p>that care is provide in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse has made an unannounced visit and will make monthly unannounced visits for one quarter and quarterly thereafter to observe each field staff providing care, to ensure that care is provided in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>The Supervising Registered Nurse has in serviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited and visits had been provided and nursing assessments provided only as ordered by the physician. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician, and that visits are provided and nursing assessments provided only as ordered by the physician.</p>	

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G 0170 Bldg. 00	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review and interview, skilled nursing failed to ensure visits, assessments, and care coordination was provided per the plan of care 9 of 9 records reviewed. (#1 - 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15, that identified skilled nursing visits were to be provided two times a week for 9 weeks. Review of the skilled nursing visit notes, the clinical record failed to evidence a second visit during week one, two, three, four, six, seven, and eight. The skilled nurse failed to follow the plan of care.</p> <p>2. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of</p>	G 0170	<p>The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p> <p>G 170 The Supervising Registered Nurse has in serviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited and visits had been provided and nursing assessments provided only as ordered by the physician. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician, and that visits are provided and nursing assessments provided only as ordered by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	10/12/2015

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	<p>08/12/15 to 10/10/15, with orders for skilled nursing visits to be provided two time a week for one week, three times a week for one week, four times a week for one week, three times a week for four weeks, four times a week for one week, and three times a week for one week. Review of the skilled nursing visit notes, the clinical record failed to evidence a fourth visit during week three. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record #3, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>4. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing one time every other week for 8 weeks for supervision, case management, assessment.</p> <p>a. Review of the skilled nursing notes failed to evidence nursing assessments and case management every</p>				

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	<p>other week. The skilled nurse failed to follow the plan of care.</p> <p>b. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. This skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>6. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing one every two weeks for 8 weeks then one time a week for one week for recertification.</p> <p>a. The plan of care indicated the skilled nurse was to assess cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled</p>			

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	<p>nurse failed to follow the plan of care.</p> <p>b. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>7. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing one time every two weeks for 8 weeks. Review of the plan of care indicated the skilled nurse was to assess the cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p> <p>8. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing one time a week for one week. Review of the skilled nursing visit notes, the clinical record failed to evidence a second visit during week two. The skilled nurse failed to follow the plan</p>			

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G 0173 Bldg. 00	<p>of care.</p> <p>9. Clinical record #9, SOC 04/13/15, included a plan of care established by the physician for the certification period 08/01/15 to 09/29/15 with orders for skilled nursing four times a week for 8 weeks then two times a week for 1 one starting the week of 08/02/15. Review of the skilled nursing visit notes, the clinical record failed to evidence a fourth visit during week two and three visits during week three. The skilled nurse failed to follow the plan of care.</p> <p>10. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The Agency will provide care / services consistent with the plan of care ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on observation, clinical record and policy review and interview, the agency</p>	G 0173	G 173 The Supervising Registered Nurse has in serviced staff on reviewing care plans on	10/12/2015

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	<p>failed to ensure plans of care were revised that included all medications for 3 of 9 records reviewed. (#1, 2, and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15.</p> <p>a. Line 21 (Orders for Discipline and Treatments) of the Plan of care indicated the patient was to receive Benedryl 25 mg (milligrams) via g/tube (gastrostomy tube) 30 to 60 minutes prior to infusion, Emla cream or LMX4 (numbing agent) cream one hour prior to accessing port, infuse Elaprase 24 mg via port a cath [catheter] once a week, dilute Elaprase in 0.9 Sodium chloride in 100 ml (milliliter) bag, flush IV [intravenous] line with normal saline and heparin, give Epinephrine 0.01 mg per kilogram for severe reaction to medication. The Medication profile failed to indicate the medications listed and the strength of the normal saline and heparin flushes.</p> <p>b. Line 21 also indicated "SN [skilled nurse] to follow all medication protocol per [Name of Pharmacy]. The plan of care failed to indicate what the medication protocol specific to the</p>		<p>an ongoing basis but no less often than 60 days and update the care plan to reflect the change, include but not limit care plan to specific discipline, frequency and duration of services, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. 100% of patient charts were audited on 10/12/2015 to ensure that care plans have been reviewed and updated and were found to be incompliance. 100% of patient charts will be audited monthly for two months and quarterly thereafter for three quarters to ensure that care plans have been reviewed and updated no less often than 60 days and that care plans include but are not limited to specific discipline, frequency and duration of service, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>medication was.</p> <p>2. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks. The plan of care failed to be updated and specific to include the the amount of visits per day and the length of time per visit specific to the payer source.</p> <p>a. Review of the recertification follow up assessment dated 08/27/15, indicated the registered nurse had been applying nystatin cream to the reddened areas in the patient's abdominal folds. The medication section of the plan of care failed to include the nystatin cream, strength, and instructions.</p> <p>b. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. The plan of care failed to include coordination of services with the wound center.</p> <p>3. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Two recertification / follow up assessments</p>			
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	<p>dated 07/10/15 and 09/08/15, indicated the patient was receiving IV infusions twice a week from an outside agency. The plan of care failed to be updated to include the IV medication and failed to be updated to include that the patient was receiving skilled nursing, physical and occupational therapy from an outside agency.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The plan of care shall include but not be limited to ... Specific discipline, frequency and duration of services ... Medications ... Orders for treatments ... The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment "</p>			

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G 0174 Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 2 of 4 home visit observations. (#1 and 2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An undated policy titled OSHA Regulations / Infection Control / Exposure Control Plan policy indicated, "The agency shall maintain policies and procedures for ... infection control practices by employees which conform with OSHA regulations and currently accepted standards of care " 2. An undated policy titled Bloodborne Pathogens indicated, "Universal precautions will be maintained during the performance of agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves " 3. An undated policy titled Infection 	G 0174	<p>G 174 The Supervising Registered Nurse has inserviced the Registered Nurses and all field staff on providing care in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Registered Nurse(Employee B) has completed additional in services on hand washing, and infection control. The Supervising Registered Nurse has made weekly unannounced visits for 2 weeks to observe Employee B during dressing changes and will make monthly unannounced visits thereafter for 3 quarters to ensure that care is provide in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse has made an unannounced visit and will make monthly unannounced visits for one quarter and quarterly thereafter to observe each field staff providing care, to ensure that care is provided in accordance with the agency's Infection Control policies and procedures</p>	10/14/2015			

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	<p>Control Program indicated, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives ... To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines "</p> <p>4. The Centers for Disease Control Standard Precautions indicated, "IV. Standard Precautions ... IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves ... IV.F.5. Include</p>		<p>andthe Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse will be responsible formonitoring these corrective actions to ensure that these deficiencies arecorrected and will not recur.</p>	

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	<p>multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently ... IV.B. Personal protective equipment (PPE) ... IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin ... could occur. "</p> <p>5. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was observed providing wound care to the patient's left ischium and coccyx wounds. Employee B was observed to don gloves after hand cleaning and remove the patient's soiled dressing, remove gloves and don new gloves, failing to wash hands or use hand sanitizer. Employee B then moistened a 4 x 4 gauze and proceeded to clean the left ischium wound with a Q-tip then moistened another 4 x 4 gauze and proceeded to clean the coccyx wound with a Q-tip, failing to change gloves and clean her hands in between wound sites. Employee B continued to pour saline in a package and cleaned the</p>						

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	<p>left ischium again with Q-tips then took the moistened 4 x 4 gauze and cleaned the patient's groin, then obtained another 4 x 4 gauze and cleaned the coccyx skin area, moving to cleaning the skin around both wounds, failing to change gloves and clean hands between tasks. After the cleaning, Employee B removed her gloves at that time and reapplied gloves without washing hands or sanitizing them. Employee B proceeded to apply santyl ointment (debriding agent that dissolves dead tissue in a wound) to a Q-tip and placed the Q-tip in the wound cavity to apply to dead tissue, then took the same Q-tip and applied more santyl to the tip and placed back in the wound bed, failing to change Q-tips with each application. Employee B continued to obtain another Q-tip and applied santyl to the tip and proceeded to apply ointment to the coccyx wound, failing to change gloves and clean hands between wounds. Employee B then obtained a new Q-tip and applied calmoseptine (skin barrier) to it and proceeded to apply the cream around the edges of the left ischium wound and coccyx wound and well as the surrounding skin, using the same Q-tip, failing to change Q-tips for new area of application. Using the same gloves and Q-tip, Employee B opened another packet of 4 x 4 and placed it in the left ischium and coccyx, then took a roll of</p>			

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	<p>kerlix gauze and cut a strip off the roll and began to pack the left ischium wound then again to the coccyx wound, applied 1 skin prep pap (skin barrier) around the skin, placed an ABD pad over both wounds and secured with tape, failing to change gloves and clean hands between wounds packing of wounds and application of skin treatment. Employee B then removed her gloves and reapplied new gloves and removed a disposable pad from underneath the patient, failing to clean her hands in between glove changes. Employee B then removed her gloves, obtained her blood pressure machine from her nursing bag, and placed the patient's wrist. Employee B returned to her nursing bag and obtained a thermometer and placed it into the patient's mouth, failing to clean hands after gloves removal.</p> <p>6. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was observed providing wound care to patient #2. After doning gloves, Employee B proceeded to clean a wound located to the left outer / lower leg then placed a piece of paper over the wound and traced the wound for measurement. Employee B proceeded to use same piece of paper and traced wounds to the right / lower shin, right / upper shin, right forearm.</p>			

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G 0176 Bldg. 00	<p>Employee B cleaned each wound with a new gauze but failed to change gloves and clean hands between each cleaning. Employee B then began checking for pedal pulses in both feet, removed gloves, don new gloves and applied new dressings to all wounds, without cleaning her hands in between glove changes.</p> <p>7. The Administrator was interviewed on 09/18/15 at 4:30 PM. The Administrator had indicated that she and Employee B had just recently reviewed infection control recently.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and interview, the Registered Nurse failed to ensure their efforts were coordinated and documented effectively with all discipline providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14, included a plan of care established by the</p>	G 0176	<p>G 176 Case conferences involving disciplines providing services for patients have been held and documented in the Coordination of care summary, as well as care coordination with outside agencies as ordered in the care plan by the physician and documented in the communication notes.</p> <p>The Administrator has in serviced staff and contractors on the effective coordination of services for all patients by all disciplines providing services and</p>	10/10/2015

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	<p>physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period</p>		<p>with other outside services, holding case conferences as well as effective documentation of coordinated services in the Coordination of care summary record and making the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that staff efforts are coordinated and documented effectively with all disciplines providing services and with other outside services that are furnishing services. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>07/26/15 to 09/23/15 with orders for skilled nursing one time every other week for 8 weeks for supervision, case management. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence services were coordinated effectively.</p> <p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence services were coordinated effectively.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence services were coordinated effectively.</p>				

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	<p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing</p>			

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G 0186 Bldg. 00	<p>services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with all disciplines providing services in 2 of 2 records reviewed receiving therapy services. (#3 and 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively. 2. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for 	G 0186	<p>G 186The Administrator has in serviced professional staffon coordination of services for all patients with other disciplines and otheroutside services that are furnishing the patient with services and documentingthe coordination of services effectively in the patient's clinical record. Caseconferences involving disciplines providing services for patients have beenheld and documented in the Coordination of care summary, as well as carecoordination with outside agencies as ordered in the care plan by thephysician and documented in the communication notes.</p> <p>The Administrator has in serviced professional staff on the effectivecoordination of services for all patients by all disciplines providing servicesand with other outside services, holding case conferences as well as effectivedocumentation of coordinated services in the</p>	10/10/2015

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G 0187 Bldg. 00	<p>skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>4. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>5. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>484.32 THERAPY SERVICES The qualified therapist prepares clinical and progress notes. Based on clinical record review and interview, the occupational therapist failed to complete an assessment upon discharge for 1 of 2 record reviewed receiving therapy services. (#8)</p> <p>Findings include:</p>	G 0187	<p>Coordination of care summary record and making the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that staff efforts are coordinated and documented effectively with all disciplines providing services and with other outside services that are furnishing services. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p> <p>G 187 The Supervising Registered Nurse has inserviced therapists on completing discharge assessments for patients upon discharge. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly to ensure that discharge assessments have been</p>	10/12/2015

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	<p>1. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for occupational therapy.</p> <p>a. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued.</p> <p>b. Review of the occupational therapy notes, the occupational therapist failed to complete a discharge assessment.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>3. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Assessment and reassessment of the client and evaluation of the client's level of function ... documentation of clinical and progress notes, summaries, and other documentation for the clinical record ... "</p>		<p>completed for all patients discharged from therapy services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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G 0202 Bldg. 00	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on record review and interview, the agency failed to ensure that the Registered Nurse updated the home health aide written care instructions in relation to patients ongoing refusal of the home health duties to be performed for 1 of 7 records reviewed (See G 223); failed to establish two written patient care instructions for the home health aides who provided care in the morning and evening for 3 of 7 records reviewed (See G 224); failed to ensure visits had been provided only as ordered by the physician in 6 of 7 records reviewed (See G 225); and failed to ensure that the home health aide provided hands on care for 1 of 7 records reviewed with home health aide services. (See G 226)</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide</p>	G 0202	<p>G 202 The Supervising Registered Nurse has inserviced Registered Nurses on following the plan of care established by the physician, notifying the physician of any changes in patient status, reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicating assessment results to the physician and making relevant changes. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly for four quarters to ensure that the Registered Nurses notified the physician of any changes in patient status, reviewed and updated care plans and aide worksheets on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicated assessment results to the physician, made relevant changes and followed the plan of care established by the physician.</p> <p>The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	10/12/2015	

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G 0223 Bldg. 00	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide is assigned to a specific patient by the registered nurse. Based on record review and interview, the agency failed to ensure that the Registered Nurse updated the home health aide written care instructions in relation to patients ongoing refusal of the home health duties to be performed for 1 of 7 records reviewed with home health aide services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, SOC (start of care) 09/29/14, included a plan of care established by the physician for certification period 07/26/15 to 09/23/15, with orders for home health aide services to provide bathing and hygiene 7 days a week for 8 weeks then 4 days a week for one week.</p> <p>a. Review of the home health visit notes between 07/26/15 to 09/07/15, the home health aide failed to provide bathing and hygiene on all visits between during this time period.</p> <p>b. Review of the supervisory visit notes dated 08/05, 08/19, and 09/02/15. The supervisory notes indicated the home</p>			G 0223	<p>G 223 The Supervising Registered Nurse has inserviced Registered Nurses on following the plan of care established by the physician, notifying the physician of any changes in patient status, reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicating assessment results to the physician and making relevant changes. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly for four quarters to ensure that the Registered Nurses notified the physician of any changes in patient status, reviewed and updated care plans and aide worksheets on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicated assessment results to the physician, made relevant changes and followed the plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		10/12/2015

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G 0224 Bldg. 00	<p>health aide was following the assigned duties and there were no changes to the home health aide care plan. The supervisory note dated 09/02/15 indicated the home health aide was present. The Registered Nurse failed to review and update the home health aide written care instructions.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>3. An undated policy titled Home Health Aide Services indicated, " The Agency shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist ... Home Health aide services shall include but not be limited to: Assisting the client to maintain personal hygiene. Assisting the client with ambulation as appropriate. Planning and preparing meals. Maintaining a health, safety environment "</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p>			

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	<p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review and interview, the Registered Nurse failed to establish two written patient care instructions for the home health aides who provided care in the morning and evening for 3 of 7 records reviewed with home health aide services. (#2, 4, and 5).</p> <p>Finding include:</p> <p>1. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks.</p> <p>Review of the home health aide visit notes, the home health aide made two visits (morning and afternoon) to the patient's home from 08/12/15 to 08/26, 08/28/15, 08/30/15, 09/03/15 to 09/06/15, and three visits on 08/27/15 and 08/29/15. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide for all visits. The clinical record failed to evidence a two - three written patient care instructions for</p>	G 0224	G 224 The Supervising Registered Nurse has in serviced Registered Nurses on establishing a two-three written patient care instructions for Home Health Aides to match the number of daily visits ordered by the physician. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that the applicable writtenpatient care instructions are in all applicable patient charts. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2015			

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	<p>each time of the day.</p> <p>2. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for home health aide services 7 days a week for 8 weeks then four days a week for one week.</p> <p>Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period on 07/27, 07/28, 07/30, 08/04, 08/06, 08/07, 08/13, 08/18, 08/20, 08/21, 08/23, 08/25, 09/01, 09/23/15. The clinical record failed to evidence a two written patient care instructions for each time of the day.</p> <p>3. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services four times a week for two weeks then two times a week for one week. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period, twice a week during week 1, 2, 3, 4, 5, 6, 8, and made two visits on 08/25/15 during week 7. The clinical record failed to evidence a two written patient care instructions for each time of the day.</p>			

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G 0225 Bldg. 00	<p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Home Health Aide Services indicated, " The Agency shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist ... Home Health aide services shall include but not be limited to: Assisting the client to maintain personal hygiene. Assisting the client with ambulation as appropriate. Planning and preparing meals. Maintaining a health, safety environment "</p> <p>484.36(c)(2) ASSIGNMENT & 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 perform under state law. Based on clinical record and policy review and interview, the Home Health Aide failed to ensure visits had been provided only as ordered by the physician in 6 of 7 records reviewed with home health aide services. (#2, 4, 5, 6, 7, and 8)</p>	G 0225	G 225 The Supervising Registered Nurse has inserviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited on 10/06/2015, and care had been	10/12/2015

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	<p>Findings include:</p> <p>1. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks.</p> <p>a. During a home visit on 09/16/15 at 8:00 AM, the patient had stated that the agency sometimes have problems staffing home health aides for both times of the day. The patient stated getting her two visits in would depend on what home health aide was working on that particular day.</p> <p>b. Review of the home health aide visit notes on 09/15/15 at 2:45 PM, the record failed to evidence a second visit was made on 08/31/15 to 09/02/15 and 08/07/15 to 09/09/15. The home health aide failed to follow the plan of care.</p> <p>2. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for home health aide services 7 days a week for 8 weeks then four days a week for one week. Review of the home health aide</p>		<p>provided and services consistent with the plan of care ordered by the physician. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>visit notes, the home health aide made two visits in a 24 hour period on 07/27, 07/28, 07/30, 08/04, 08/06, 08/07, 08/13, 08/18, 08/20, 08/21, 08/23, 08/25, 09/01, 09/23/15. The home health aide failed to follow the plan of care.</p> <p>3. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services four times a week for two weeks then two times a week for one week. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period, twice a week during week 1, 2, 3, 4, 5, 6, 8, and made two visits on 08/25/15 during week 7. The home health aide failed to follow the plan of care.</p> <p>4. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for attendant care services one time a week for one week, 5 times a week for 8 weeks, then one time a week for one week.</p> <p>A signed physician order dated 08/20/15, indicated to discontinue attendant care services and to start home health aide services two times a week for</p>			

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	<p>one week, 5 times a week for 6 weeks, then one time a week for one week.</p> <p>Review of the attendant care and home health aide visit notes, the attendant care continued to see the patient on 08/22 and 08/23/15. The home health aide made his / her first visit on 08/24/15. The attendant care and home health aide failed to follow the plan of care.</p> <p>5. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services three times a week for 8 weeks then two times a week for one week and homemaker services two times a week for 9 weeks.</p> <p>a. Review of the home health aide visit notes, the clinical record failed to evidence that no home health aide provided services between 07/12/15 to 08/17/15. The home health aide failed to follow the plan of care.</p> <p>b. Review of the homemaker visit notes revealed that two extra visits (total of 4 visits) were made between 08/25/15 to 08/28/15. The homemaker failed to follow the plan of care.</p> <p>6. Clinical record #8, SOC 07/30/15, included a plan of care established by the</p>			

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	<p>physician for the certification period 07/30/15 to 09/27/15 with orders for home health aide services one time a week for one week then three times a week for 8 weeks.</p> <p>a. Review of the home health aide visit notes, the clinical record failed evidence that two visits were made during week two. The home health aide failed to follow the plan of care.</p> <p>b. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued and homemaker services would start the week of 08/09/15, three times a week for 7 weeks. Review of the homemaker visit notes, the clinical record failed to evidence that two visits were made during week 5, three visits were made during week 6, one visit during week 7, and three visits were made during week 8. The homemaker failed to follow the plan of care.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>3. An undated policy titled Home Health Aide Services indicated, " The Agency</p>						

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G 0226 Bldg. 00	<p>shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist "</p> <p>484.36(c)(2) ASSIGNMENT & 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. Based on record review and interview, the agency failed to ensure that the home health aide provided hands on care for 1 of 7 records reviewed with home health aide services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, SOC (start of care) 09/29/14, included a plan of care established by the physician for certification period 07/26/15 to 09/23/15, with orders for home health aide services to provide bathing and hygiene 7 days a week for 8 weeks then 4 days a week for one week. Review of the home health visit notes between 07/26/15 to 09/07/15, the home health aide failed to provide</p>	G 0226	G 226 The Supervising Registered Nurse has inserviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited on 10/06/2015, and care had been provided and services consistent with the plan of care ordered by the physician. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/12/2015

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G 0235 Bldg. 00	<p>bathing and hygiene on all visits between during this time period.</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p>	G 0235	<p>G235 The Supervising Registered Nurse has in serviced Registered Nurses onensuring that documentation is written and maintained to verify that the timerequirement for completing initial assessment (24-48 hours of referral ordischarge from a facility unless otherwise ordered by a physician.) is met bythe use of the referral log. which will be easily accessible.The SupervisingRegistered Nurse has updated the referral log and will audit the referral logmonthly and quarterly to ensure that the referral log is well documented withall the referrals, it is maintained by qualified staff and is easily accessibleto be used to ascertain that the time requirement has been met for initialassessments. 100% of initial assessment dates will be audited against thereferral data in the referral log to ensure that the time requirement forcompleting assessments was met.The SupervisingRegistered Nurse is responsible for monitoring these corrective actions toensure that these deficiencies are corrected and will not recur.</p>	10/09/2015

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G 0236 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>1A. Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p> <p>Findings include:</p> <p>1A. Patient record #1, SOC (start of care) 11/27/13. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>2A. Patient record #2, SOC 12/15/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to</p>	G 0236	G 236 The Supervising Registered Nurse has in serviced Registered Nurses onensuring that documentation is written and maintained to verify that the timerequirement for completing initial assessment (24-48 hours of referral ordischarge from a facility unless otherwise ordered by a physician.) is met bythe use of the referral log. which will be easily accessible.The SupervisingRegistered Nurse has updated the referral log and will audit the referral logmonthly and quarterly to ensure that the referral log is well documented withall the referrals, it is maintained by qualified staff and is easily accessibleto be used to ascertain that the time requirement has been met for initialassessments. 100% of initial assessment dates will be audited against thereferral data in the referral log to ensure that the time requirement forcompleting	10/09/2015	

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	<p>provide information to verify that the time requirement was met.</p> <p>3A. Patient record #3, SOC 06/24/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>4A. Patient record #4, SOC 09/24/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>5A. Patient record #5, SOC 09/25/12. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>6A. Patient record #6, SOC 02/13/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>7A. Patient record #7, SOC 01/13/15. The clinical failed to ensure initial assessments were completed within 48</p>		<p>assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>8A. Patient record #8, SOC 07/30/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>9A. Patient record #9, SOC 04/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>10A. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11A. An undated policy titled Referral and Acceptance of Clients indicated, "The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained ... Clients will be evaluated by a nurse or appropriate staff member within 24 - 48</p>			

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	<p>hours of referral or discharge from a facility unless otherwise ordered by the physician ... "</p> <p>B. Based on record review and interview, the agency failed to ensure clinical records were complete and current in relation to missing visit notes for * of 9 records reviewed.</p> <p>Findings include:</p> <p>1B. Clinical record #2, SOC 12/15/14, failed to evidence home health aide visit notes after 09/09/15 and skilled nursing visit notes after 09/11/15.</p> <p>2B. Clinical record #3, SOC 06/24/15, failed to evidence home health aide visit notes after 09/11/15, physical therapy notes after 09/02/15 and occupational therapy notes after 09/04/15.</p> <p>3B. Clinical record #4, SOC 09/29/14, failed to evidence home health aide visit notes 09/07/15.</p> <p>4B. Clinical record #5, SOC 09/25/14, failed to evidence home health aide visit notes after 09/05/15.</p> <p>5B. Clinical record #6, SOC 02/13/14, failed to evidence home health aide visit</p>			

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	<p>notes after 09/08/15.</p> <p>6B. Clinical record #7, SOC 01/13/15, failed to evidence home health aide visit notes after 09/03/15.</p> <p>7B. Clinical record #8, SOC 07/30/15, failed to evidence attendant care visit notes after 08/17/15.</p> <p>8B. Clinical record #9, SOC 04/03/15, failed to evidence skilled nursing visit notes after 09/09/15.</p> <p>9B. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator stated that the time frame allowed for clinicians to turn in documentation following a visit is 48 hours and 7 days for documents to be filed in the patient records.</p> <p>10B. After the entrance conference on 09/15/15 at 12:00 PM, the Administrator was instructed to provide all patient records at once for review. At 12:20 PM, only one record had been provided. The Administrator was observed taking a record to the front reception desk area. At 1:15 PM, the Administrator was interviewed on reason for delay of clinical records. The Administrator stated that she was making sure the charts were complete due to her office manager</p>			

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G 0330 Bldg. 00	<p>had quit the previous week and she was behind on filing. On 09/18/15 at 2:00 PM, the Administrator was given the opportunity to provide any missing documentation to the surveyor that was not in the patients record.</p> <p>11B. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the</p>						

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	<p>Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed (See G 332); failed to ensure the medication profiles were revised and accurate for 4 of 9 records reviewed (See G 337); and failed to ensure that a oasis comprehensive assessment and occupational summary was completed upon discharge for 1 of 2 record reviewed for discharge. (See G 341).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.55 Comprehensive Assessment.</p>	G 0330	G330 The Supervising Registered Nurse has in serviced Registered Nurses onensuring that documentation is written and maintained to verify that the timerequirement for completing initial assessment (24-48 hours of referral ordischarge from a facility unless otherwise ordered by a physician.) is met bythe use of the referral log. which will be easily accessible. The SupervisingRegistered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented withall the referrals, it is maintained by qualified staff and is easily accessibleto be used to ascertain that the time requirement has been met for initial assessments. 100% of initial assessment dates will be audited against the referral data in the referral log to ensure that the time requirement forcompleting assessments was met. The SupervisingRegistered Nurse is responsible for monitoring these corrective actions toensure that these	10/12/2015	

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			<p>deficiencies are corrected and will not recur.</p> <p>The Supervising Registered Nurse has in serviced staff on reviewing care plans on an ongoing basis but no less often than 60 days and updating the care plan to reflect the change, update medication orders for treatment and notify physician immediately of any change in the client's condition which indicate changes to the plan of treatment. 100% of patient charts were audited on 10/12/2015 to ensure that care plans have been reviewed and updated and were found to be incompliance. 100% of patient charts will be audited monthly for two months and quarterly thereafter for three quarters to ensure that care plans have been reviewed and updated no less often than 60 days and that care plans include but are not limited to specific discipline, frequency and duration of service, medication orders for treatment have been revised and are accurate, and physician has been notified immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The Supervising Registered Nurse has in serviced therapists on completing discharge</p>	

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G 0332 Bldg. 00	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p> <p>Findings include:</p> <p>1. Patient record #1, SOC (start of care) 11/27/13. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p>	G 0332	<p>assessments and summary for patients upon discharge. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly to ensure that discharge assessments and summary have been completed for all patients discharged from therapy services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>G332 The Supervising Registered Nurse has in serviced Registered Nurses on ensuring that documentation is written and maintained to verify that the time requirement for completing initial assessment (24-48 hours of referral or discharge from a facility unless otherwise ordered by a physician.) is met by the use of the referral log, which will be easily accessible. The Supervising Registered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented with all the referrals, it is maintained by qualified staff and is easily accessible to be used to ascertain that the time</p>	10/09/2015	

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	<p>2. Patient record #2, SOC 12/15/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>3. Patient record #3, SOC 06/24/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>4. Patient record #4, SOC 09/24/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>5. Patient record #5, SOC 09/25/12. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>6. Patient record #6, SOC 02/13/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p>		<p>requirement has been met for initial assessments. 100% of initial assessment dates will be audited against thereferral data in the referral log to ensure that the time requirement for completing assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>7. Patient record #7, SOC 01/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>8. Patient record #8, SOC 07/30/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>9. Patient record #9, SOC 04/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>10. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11. An undated policy titled Referral and Acceptance of Clients indicated, "The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral</p>			

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G 0337 Bldg. 00	<p>information. A log of all persons referred for service will be maintained ... Clients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility unless otherwise ordered by the physician ... "</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, clinical record and policy review and interview, the agency failed to ensure the medication profiles were revised and accurate for 4 of 9 records reviewed. (#1, 2, 3, and 7) Findings include: 1. Clinical record #1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15. Line 21 (Orders for Discipline and Treatments) of the Plan of care indicated the patient was to receive Benedryl 25 mg (milligrams) via g/tube (gastrostomy tube) 30 to 60 minutes prior to infusion,</p>			G 0337	G337 The Supervising Registered Nurse has in serviced staff on reviewing care plans on an ongoing basis but no less often than 60 days and updating the care plan within 5 days to reflect the change, and that medication records are revised and accurate to include all patient's current medications and indicate discontinued medications and or treatments, that physician is notified immediately of any change in the client's condition which indicate changes to the plan of treatment. 100% of patient charts were audited on 10/12/2015 to ensure that care plans were reviewed and updated, medication profiles revised and accurate and were found to be in compliance. 100%		10/12/2015

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	<p>Emla cream or LMX4 (numbing agent) cream one hour prior to accessing port, infuse Elaprase 24 mg via port a cath [catheter] once a week, dilute Elaprase in 0.9 Sodium chloride in 100 ml (milliliter) bag, flush IV [intravenous] line with normal saline and heparin, give Epinephrine 0.01 mg per kilogram for severe reaction to medication. The Medication profile failed to indicate the medications listed and the strength of the normal saline and heparin flushes.</p> <p>2. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15.</p> <p>a. Review of the recertification follow up assessment dated 08/27/15, indicated the registered nurse had been applying nystatin cream to the reddened areas in the patient's abdominal folds. The medication profile failed to be updated to include the nystatin cream, strength, and instructions.</p> <p>b. Review of skilled nursing notes indicated on 08/28/15, the patient was started on Diflucan due to a yeast infection in the abdominal folds. The medication profile failed to be updated to include the Diflucan, strength, and instructions.</p>		<p>of patient charts will be audited monthly for two months and quarterly thereafter for three quarters to ensure that care plans were reviewed and updated, medication profiles revised and accurate and that physician was notified immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>3. Clinical record #3, SOC 06/24/15, included a plan of care established by the physician for the certification period 08/23/15 to 10/21/15.</p> <p>a. Upon reviewing a medication list during a home visit on 09/16/15 at 11:30 AM with patient #3, the patient had stated that she was no longer taking Norco and no longer using Duragesic patches (both are pain medications). The patient also indicated she was no longer taking Prednisone (anti-inflammatory medication) and the oxygen use was not continuous but intermittent use. The medication profile failed to be updated to indicate the discontinuation of the medication.</p> <p>b. Review of a skilled nursing visit note dated 08/28/15, indicated the patient was taking Bactrim DS twice a day for 10 days for infection prevention. The medication profile failed to be updated to include the antibiotic medication.</p> <p>4. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Two skilled nursing visit notes dated 07/10/15 and 09/08/15, indicated the patient was receiving IV infusions twice a week from</p>			

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G 0341 Bldg. 00	<p>an outside agency. The medication profile failed to be updated to include the IV medication.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The plan of care shall include but not be limited to ... Medications ... Orders for treatments ... The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment "</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review and interview, the agency failed to ensure that a oasis comprehensive assessment and occupational summary was completed upon discharge for 1 of 2 record reviewed for discharge. (#8)</p> <p>Findings include:</p>	G 0341	G 341 The Supervising Registered Nurse has in serviced professional staff on updating and revising comprehensive assessments including the administration of Oasis upon discharge. The Supervising Registered Nurse has audited 100%of patient charts (10/06/2015) to ensure that discharge assessments have been conducted at discharge.	10/06/2015			

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	<p>1. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy.</p> <p>a. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued.</p> <p>b. Review of the skilled nursing visit notes, the skilled nurse failed to complete a comprehensive discharge oasis.</p> <p>c. Review of the occupational therapy notes, the occupational therapist failed to complete a discharge assessment.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>3. An undated policy titled Discharge Planning, Discharge Summary and Discharge OASIS indicated, " ... The discharge comprehensive assessment and OASIS data collection is required for all situations that result in an Agency</p>		<p>The Supervising Registered Nurse will follow up on every discharge to ensure that there is a discharge assessment and in the case of Medicare patients a Discharge oasis assessment The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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N 0000 Bldg. 00	<p>discharge ... If the discharge comprehensive assessment and OASIS data collection cannot be completed in conjunction with the last (discharge) visit, responses to the OASIS data items must be based on the clinical findings documented at the time of the last skilled visit. The visit date used to complete the OASIS assessment must be documented on the discharge comprehensive assessment. In cases with multiple disciplines and there are multiple points of discipline specific discharges, there is only one Agency discharge, and the Agency discharge is the only one which requires a comprehensive assessment and OASIS data collection ... "</p> <p>The was a State re-licensure survey. The survey was extended.</p> <p>Survey dates: 09/15/15 to 09/18/15</p> <p>Facility ID#: 003563</p> <p>Medicaid #: 200450280</p> <p>Provider #: 157559</p> <p>Census: 9</p>	N 0000		

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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 agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency.</p> <p>Finding included:</p> <ol style="list-style-type: none"> On 9/15/15 at 11:30 AM, the organizational chart was requested. The organizational chart provided indicated titles / positions but failed to include the name of employees under the title / position. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above. A policy titled Administrative Control dated 03/2009, indicated "The Organizational chart defines lines of 	N 0440	<p>N440 The Administrator has updated the organizational chart to includethe names of the employees under the titled positions in the organizationalchart.The Administrator has in serviced administrative staff on including the namesof the employees under the titled positions in the organizational chart. Theadministrator will perform quarterly checks and as often as needed with staffchanges to ensure that the names of the employees under the titled positionsare included in the organizational chart.The Administrator is responsible for monitoring this corrective action toensure that this deficiency is corrected and will not recur.</p>	10/01/2015			

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N 0444 Bldg. 00	<p>authority for the delegation of responsibility and accountability down to the patient care level ... "</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. A. Based on record review and interview, the Administrator failed to ensure home health aide had a written competency test in 4 of 4 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015. (#C, D, F, G, and I)</p> <p>Findings include:</p> <p>1A. Personnel file C evidenced the individual had been hired on 10/11/12 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2014.</p>	N 0444	N444 A The Administrator has ensured that all Home Health Aides employed by the agency have completed the written competency test and that the writtencompetency test and skills tests have been filed timely and appropriately in each Home Health Aide's file. The Administrator has inserviced office staff to ensure proper and timely filing of documents inemployee files. The Administrator has reviewedthe requirements of the Home Health Aide Program with the contractor. The Administrator willensure that Home Health Aides that are employed by the agency are qualified andcompetent, have completed the competency evaluation program comprising of thecompetency skills test and	10/12/2015

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	<p>2A. Personnel file D was not provided.</p> <p>3A. Personnel file F evidenced the individual had been hired on 08/26/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee.</p> <p>4A. Personnel file G evidenced the individual had been hired on 04/21/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2015.</p> <p>5A. Personnel file I evidenced the individual had been hired on 02/09/15 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee.</p> <p>6A. On 09/17/15 at 10:50 AM, employee files were requested to the Administrator. By 12:10 PM, the employee files still were not provided. Upon entering a back office where the Administrator and her Alternate was sitting, Personnel file C was found to be on a table and opened, along with other personnel files on the table. The files were immediately removed from the room. The</p>		<p>written exam and that the tests are filed timely and appropriately in each Home Health Aide's file. 100% of the Home Health Aide files have been audited to ensure that there is written documentation maintained in each HHA's files to confirm the completion of the program. A monthly audit of 100% of Home Health Aide files will be conducted to ensure that each HHA has completed the competency evaluation program comprising of the competency skills test and written examination and that there is written documentation maintained in each HHA's files to confirm the completion of the program. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performance reviews are conducted by the appropriate supervisor on completion of three months of employment, annually thereafter for non-exempt employees and annually for exempt employees. 100% of employee files have been audited to ensure that the 3 month performance reviews for new nonexempt, annually thereafter for non-exempt employees and exempt employees have been performed and documented in</p>		

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	<p>Administrator had indicated she was making sure that records were complete and correct for review and that loose papers were secured. At 4:30 PM, the Administrator stated Employee D did have a personnel file but she was unable to locate it.</p> <p>7A. An undated policy titled Performance Evaluation indicated, "All non-exempt employees shall be evaluated by the appropriate supervisor upon completion of three (3) months of employment, and annually thereafter. Exempt employees shall be evaluated yearly "</p> <p>8A. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>B. Based on record review and interview, the Administrator failed to update a written contract for the provision of a Registered Nurse for 1 of 2</p>		<p>theiremployee files. 100%of employee files will be audited quarterly for 4 quarters to ensure that the 3month performance reviews for new nonexempt and exempt employees and annuallythereafter for non-exempt employees and exempt employees have been performedand documented in their employee files. B The Administrator has evaluated and updatedthe written contract for the provision of a Registered Nurse to reflect all theservices provided by the contractor and ensure that all elements of thecontract align with the agency policies including timeliness of submission of clinicalrecords. The Administrator will ensurethat the agency conducts contract evaluations at least annually and prior tocontract renegotiation to identify problems or opportunities forimprovement, updates contracts to reflect all services provided by thecontractor and that all elements of the contract align with the agencypolicies, and determine if contract is to be reviewed or terminated.100% of contractshave been audited and will be audited quarterly for 4 quarters to ensure thatcontracts have been evaluated annually, and prior to contract renegotiation toidentify problems or opportunities for improvement, and determine ifcontract is to be reviewed or terminated, that contracts are</p>		

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	<p>contracts reviewed.</p> <p>Findings include:</p> <p>1B. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator had stated that clinical visit notes were to be in the office within 48 hours following a visit.</p> <p>2B. During a home visit on 09/15/15 at 4:30 PM, Employee D, a Registered Nurse, was observed providing an Intravenous Infusion and assessment to patient #1.</p> <p>3B. Review of Employee D contract dated 07/09/10, the contract indicated Employee D was to provide only Inservice Training and testing of home health aides for home health aide competency evaluation program and consultation. The contract also indicated, "Contractor agrees to submit documentation of the services provided in accordance with the record keeping requirements of Agency ... on a bi-weekly basis on the MOnday of each pay period week prior to 10:00 AM "</p> <p>4B. The Administrator was interviewed on 09/17/15 at 3:00 PM. The Administrator stated on page 8 of the contract, she had indicated</p>		<p>updated to reflect all services provided by the contractor and that all elements of the contract align with the agency policies. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The Supervising Registered Nurse has in serviced professional staff on reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days. 100% 100% of patient charts have been audited and !00% of patient's charts will be audited quarterly for four quarters to ensure that care plans are reviewed and updated on an ongoing basis within 5 days of identifying change but no less than every 60 days. The Supervising Registered Nurse is responsible for monitoring the corrective action on care plans to ensure that the deficiency is corrected and will not recur 6B. The Supervising Registered Nurse has in serviced professional staff on the maintenance of clinical records for all patients in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation and agency policies. 100% of charts have been audited will be audited quarterly for four quarters to ensure that notes are written the day of the</p>		

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	<p>reimbursement for skilled follow up visit and thought that was sufficient to allow Employee D to see patients. The Administrator did not have any further information regarding the timeliness of turning in paperwork.</p> <p>5B. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6B. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p> <p>7B. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior</p>		<p>service delivery and filed in the appropriate chart at least weekly The Supervising Registered Nurse is responsible for monitoring the corrective action on care plans to ensure that the deficiency is corrected and will not recur. 7B The Administrator will ensure that the agency evaluates services at least annually and prior to the contract renegotiation process to identify problems or opportunities for improvement and if the contract is to be revised, renewed or terminated. 100% of contracts have been evaluated and will be audited quarterly for 4 quarters to ensure that the agency evaluated services at least annually and prior to the contract renegotiation process to identify problems or opportunities for improvement and if the contract is to be revised, renewed or terminated. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. C. The Administrator has in serviced staff and contractors on the coordination of services for all patients by all disciplines providing services and with other outside services furnishing services. All staff providing services to patient are to participate in the Case conferences and effectively document case conference in the Coordination of care summary and use</p>		

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	<p>to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>C. Based on observation, clinical record and policy review and interview, the Administrator failed to ensure agency efforts were coordinated and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1C. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p>		<p>Communicationnotes to document coordination with outside services furnishing services topatient and make the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will beaudited quarterly for 4 quarters to ensure that agency efforts are coordinated anddocumented effectively in the patient's chart by all disciplines providingservices and with other outside services furnishing services to the patient. The Administrator is responsible for monitoring this correctiveaction to ensure that this deficiency is corrected and will not recur. D The Administrator has reviewed the agency'spolicies on Quality Assessment and Performance Improvement Program. TheAdministrator will ensure that the agency's Quality Assurance Program complieswith the Indiana State laws and regulation by ensuring an ongoing qualityassurance program that monitors and evaluates the quality and appropriatenessof patient care, resolves identified problems and improves patientcare. The agency will select indicators to monitor that span the scope ofthe agency's services using tools that include but are not limited toidentified or potential problems (observed or reported), patient surveys orquestionnaires and incident</p>		

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	<p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2C. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3C. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also has services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service</p>				<p>reports and a final selection made through prioritization. The Administrator has checked to ensure that the indicators being monitored span the scope of the agency's services and that the data collected for September is well documented, monitors and evaluates the quality and appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. E The Advisory Committee has reviewed the Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care clinical records, personnel qualification and program evaluation including quality improvement program. The Administrator will monitor bi-annually to ensure that the Advisory committee advises the Agency on professional issues and</p>		

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	<p>agencies.</p> <p>4C. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5C. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6C. Clinical record #7, SOC 01/13/15, included a plan of care established by the</p>		<p>participates in the Annual evaluation of the Agency program including quality improvement program and documents all proceedings in the minutes. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of the disciplines that will furnish care, type of care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits and specify these on the admission Service Agreement in terms that the patient can understand. Admission service agreements have been updated and provided to patients stating disciplines that will furnish care, type of care to be provided, frequency and duration of the proposed visits, as well as verbal explanations to the patients. 100% of patient charts will be audited quarterly for evidence that patients were informed of the care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits and specify these on the Admission Service Agreement in terms that the patient can understand. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that</p>		

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	<p>physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7C. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8C. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9C. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p>		<p>these deficiencies are corrected and will not recur. G. The SupervisingRegistered Nurse has in serviced professional staff on notifying patients onadmission and as often as necessary, verbally and in writing the charges forservices, client and agency responsibilities for care and any financialresponsibilities including the cost of care and charges for services that maynot be covered and that the individual may have to pay for. Admission serviceagreements have been updated and provided to patients stating the charges forservices, client and agency responsibilities for care and any financialresponsibilities including the cost of care and charges for services that maynot be covered and that the individual may have to pay for as well as verbalexplanations to the patients. 100% of patient charts will be audited quarterlyfor evidence that patients were informed of the charges for services, clientand agency responsibilities for care and any financial responsibilitiesincluding the cost of care and charges for services that may not be covered andthat the individual may have to pay for. The SupervisingRegistered Nurse is responsible for monitoring these corrective actions toensure that these deficiencies are corrected and will not recur. H The SupervisingRegistered Nurse has</p>		

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	<p>10C. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11C. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>D. Based on record review and interview, the Administrator failed to ensure the agency complied with Indiana State laws and regulation 410 IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients.</p> <p>Findings include:</p> <p>1D. 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</p>		<p>in serviced Registered Nurses on ensuring that documentation is written and maintained to verify that the time requirement for completing initial assessment (24-48 hours of referral or discharge from a facility unless otherwise ordered by a physician.) is met by the use of the referral log. which will be easily accessible. The Supervising Registered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented with all the referrals, it is maintained by qualified staff and is easily accessible to be used to ascertain that the time requirement has been met for initial assessments. 100% of initial assessment dates will be audited against the referral data in the referral log to ensure that the time requirement for completing assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. I The Administrator has in serviced healthcare professionals on maintaining the clinical record in such a manner that it is current, assembled and filed in a timely manner in accordance with law and regulation. 100% of patient charts were audited by 10/06/2015 and will be audited quarterly thereafter to ensure that</p>		

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	<p>quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>2D. The Administrator provided a quality improvement binder for first and second quarter review on 09/18/15 at 4:45 PM.</p> <p>a. The first quarter compliance percentage included 485 (Plan of Care) signatures at 100%, Dr. orders at 100%, Medical Professionals with signatures at 60%, Communication Letter / 60 day summaries at 100%, Consents with patient signatures at 100%, and Supervisory visits at 100%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>b. The second quarter compliance percentage included 485 signatures at 88%, Dr. orders at 100%, Medical Professions with signatures at 100%, Communication letter / 60 day summaries at 100%, Consents with patient signatures at 100%, Supervisory visits at 100%, Assessments with signatures at 77.7%, and Notes with signature dates at 77.7%. The quality improvement program failed to evidence</p>		<p>all documents are assembled and filed in a timely manner and in accordance with law and regulation. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur J. The administrator has reviewed agency policies and has put into place many changes to make the agency ongoing functions effective as evidenced in this plan of correction. The Administrator will perform her administrative duties and ensure that the agency is in compliance with all federal, state, and local regulations related to the delivery of home health care The Administrator will send out quarterly questionnaires for four quarters to employees, Board of Directors, Advisory Committee and patients to assess the effectiveness of the Administrator</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>				

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	<p>quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>3D. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>4D. An undated policy titled Quality Assessment and Performance Improvement Program indicated, " ... Objectives: To maintain and improve the highest quality client care and to reduce or eliminate risks and hazards within the client's environment by: [left blank]; Administering and coordinating the Agency's performance improvement program which is designed to ensure all performance improvement activities are implemented. Identifying and prioritizing opportunities to improve client care using ongoing collection and / or screening and evaluating information about outcomes of health care and customer satisfaction. Tracking identified problems to ensure improvement or resolution. Developing and implementing effective performance improvement mechanisms such as monitoring and evaluation committees, incident reporting and trending, and</p>			

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	<p>client / physician questionnaires. Documenting the findings, conclusions, recommendations, actions taken, and results of actions taken using defined statistical process. Overseeing the effectiveness of the program and detection of trends, patterns of performance or potential problems that may affect more than one office or department. Improving communication among staff and offices when problems or opportunities to improve client care arises. Ensuring performance based credentialing and competency for each professional and paraprofessional caregiver; identifying marginal or substandard performers for enhanced training or termination as appropriate. Evaluating at least annually the scope, organization and effectiveness of the performance improvement program ensuring that actions taken are in pursuit of the objectives of this program and within the mission and goals of the Agency. This evaluation is submitted to the Board of Director for review, identifying actual, potential client care problems, evaluating the Agency mechanism for addressing client care problems, identifying the need for revisions in client care services, policies and procedures. Evaluating the adequacy of documentation of client care services. Identifying the extent to which the</p>			

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	<p>Agency program is adequate, effective, and efficient in use of all manpower and financial resources. Regularly collecting, aggregating, and analyzing data on staff competency. The agency's quality assessment and performance improvement program consists of but is not limited to the following: Program / staff performance assessment activities. Staff recruitment, training, orientation and continuing education programs, case conferences, management meetings, ongoing review of clinical records, clinical staff peer review activities, clinical record / utilization review, clinical staff competency testing program, review of records requested by peer review, management systems that support infection control functions, client / physician / staff satisfaction assessment, performance improvement plans, risk management program, sentinel event action plan, performance control activities, and annual program evaluation.</p> <p>E. Based on record review and interview, the Administrator failed to ensure a group of professional personnel had annually reviewed the agency's policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation as required creating the potential to affect</p>			

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	<p>all of the agency's current 9 patients.</p> <p>Findings include:</p> <p>1E. The agency's administrative records included an "Advisory Committee Meeting" minutes dated 02/13/15. The attendance included a Registered Nurse, Community Member, and Administrator. The minutes indicated [name of Physician] had an "excused absence." Topics discussed were 2014 Annual Report, stalemate in the census, advertising, Quality Improvement Program, and staff retention. The Advisory Committee failed to evidence and discuss Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification and program evaluation. The minutes failed to evidence quality improvement program issues and interventions.</p> <p>2E. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>3E. An undated policy titled Organizational Guidelines indicated, " ...</p>			

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	<p>Duties of the Advisory Committee: The Advisory Committee shall: Establish and annually review the Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification and program evaluation, Advise the Agency on professionals issues, Participate in the annual evaluation of the Agency's program "</p> <p>F. Based on record review and interview, the Administrator failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 4 of 9 records reviewed. (#2, 7, 8, and 9)</p> <p>Findings include:</p> <p>1F. Clinical record #2, SOC (start of care) 12/15/14. The Admission Service Agreement dated 12/15/14, indicated the patient was to receive home health aide services for bathing and ADLs (activities of daily living). The Admission Service Agreement failed to evidence the frequency of the proposed visits.</p> <p>2F. Clinical record #7, SOC 01/13/15.</p>			

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	<p>The Admission Service Agreement dated 01/13/15, indicated the patient were to receive home health aide services three times a week and homemaker services two times a week. The "Planned Treatment" was left blank. The Admission Service Agreement failed to evidence the scope of services that was to be provided by the home health aide and homemaker. The Admission Service Agreement failed to evidence the length of services to be provided.</p> <p>3F. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive physical therapy and occupational therapy. The Admission Service Agreement failed to evidence the frequency proposed and plan of treatment for physical and occupational therapy.</p> <p>4F. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing three times a week for "assessment, medication administration per 485." The Admission Service Agreement failed to specify in terms that the patient can understand (485) for planned treatment and failed to specify duration of services to be provided.</p>			

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	<p>5F. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>6F. An undated policy titled Client Rights indicated, " ... The client has the right to be informed about the care to be furnished, and of any changes in the care to be furnished ... "</p> <p>7F. An undated policy titled Informed Consent indicated, "An informed consent will be explained to and signed by all clients or the client's legal representative prior to admission. Explanation of the informed consent ensures that all client / families are informed about the type of care and services provided during the course of illness and that the client / family consent to such ... "</p> <p>8F. An undated policy titled Client Rights / Responsibilities indicated, " ... On admission and as often as necessary, verbally and in writing, client and Agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to the care / services provided by the Agency will be provided to the client / caregiver(s) ... "</p>			

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	<p>G. Based on clinical record review and interview, the Administrator failed to ensure the agency informed patients, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 9 of 10 records reviewed. (#1 - 4, 6 - 9)</p> <p>Findings include:</p> <p>1G. Clinical record number 1, SOC (start of care) 11/27/13. The Admission Service Agreement dated 11/27/13, indicated "Charge: 0." The Amount Insurance pays and the amount the patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>2G. Clinical record #2, SOC date 12/15/14. During a home visit on 09/16/15 at 08:00 AM, the patient had stated that she did not know if the services she was receiving was under Medicare, Medicaid, and / or Waiver services. The Admission Service Agreement dated 11/27/13, the Charge section, amount insurance pays, and amount patient pays was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and</p>			

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	<p>the charges that may occur for services not covered by the insurance benefit.</p> <p>3G. Clinical record #3, SOC date 06/24/15. The Admission Service Agreement dated 06/24/15, indicated "Charge: 0 / Amount Insurance Pays: Medicare rate / Amount patient pays: 0." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>4G. Clinical record #4, SOC 09/24/14. The Admission Service Agreement dated 09/24/14, indicated "Charge: 0 / Amount Insurance Pays: Per Medicaid Notes / Amount Patient Pays: Per spenddown if applicable." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>5G. Clinical record #6, SOC 02/13/14. The Admission Service Agreement dated 02/13/14, indicated "Charge: 0 / Amount Insurance Pays: Per [Name of council on aging agency] notes / Amount of Patient Pays: Per [Name of council on aging agency] notes." The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p>			

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	<p>6G. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated, "Amount Insurance Pays: per Medicaid rates / Amount Patient Pays: 0." The "Charge" section was left blank. The The Admission Service Agreement failed to evidence charges that may occur for services not covered by the insurance benefit.</p> <p>7G. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive skilled nursing one time a week for 9 weeks, physical therapy, occupational therapy, and home health aide services three times a week for 9 weeks. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was left blank. The Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>8G. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing services three times a week. The Charge section, amount insurance pays, and amount patient pays, of the Admission Service Agreement was left blank. The</p>			

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	<p>Admission Service Agreement failed to evidence specific insurance coverage and the charges that may occur for services not covered by the insurance benefit.</p> <p>9G. The Administrator, a Registered Nurse, on 09/18/15 at 4:30 PM. The Administrator indicated patient number 2 was receiving Medicare, Medicaid, and Waiver services with the agency. The Administrator was asked and unable to provide any further documentation and / or information regarding the findings.</p> <p>10G. An undated policy titled Notification of Financial Responsibility and Non coverage, Home Health Agency Beneficiary Notice (HHABN) indicated, "All clients determined to be eligible for care and service by the Agency will be informed verbally and in writing regarding any financial responsibility for care and any non covered care or service "</p> <p>1H. Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p>			

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	<p>Findings include:</p> <p>1H. Patient record #1, SOC (start of care) 11/27/13. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>2H. Patient record #2, SOC 12/15/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>3H. Patient record #3, SOC 06/24/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>4H. Patient record #4, SOC 09/24/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>5H. Patient record #5, SOC 09/25/12. The clinical failed to ensure initial assessments were completed within 48</p>				

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	<p>hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>6H. Patient record #6, SOC 02/13/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>7H. Patient record #7, SOC 01/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>8H. Patient record #8, SOC 07/30/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>9H. Patient record #9, SOC 04/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>10H. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable</p>				

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	<p>to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11H. An undated policy titled Referral and Acceptance of Clients indicated, "The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained ... Clients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility unless otherwise ordered by the physician ... "</p> <p>I. Based on record review and interview, the agency failed to ensure clinical records were complete and current in relation to missing visit notes for 8 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, 8, and 9).</p> <p>Findings include:</p> <p>1I. Clinical record #2, SOC 12/15/14, failed to evidence home health aide visit notes after 09/09/15 and skilled nursing visit notes after 09/11/15.</p> <p>2I. Clinical record #3, SOC 06/24/15,</p>			

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	<p>failed to evidence home health aide visit notes after 09/11/5, physical therapy notes after 09/02/15 and occupational therapy notes after 09/04/15.</p> <p>3I. Clinical record #4, SOC 09/29/14, failed to evidence home health aide visit notes 09/07/15.</p> <p>4I. Clinical record #5, SOC 09/25/14, failed to evidence home health aide visit notes after 09/05/15.</p> <p>5I. Clinical record #6, SOC 02/13/14, failed to evidence home health aide visit notes after 09/08/15.</p> <p>6I. Clinical record #7, SOC 01/13/15, failed to evidence home health aide visit notes after 09/03/15.</p> <p>7I. Clinical record #8, SOC 07/30/15, failed to evidence attendant care visit notes after 08/17/15.</p> <p>8I. Clinical record #9, SOC 04/03/15, failed to evidence skilled nursing visit notes after 09/09/15.</p> <p>9I. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator stated that the time frame allowed for clinicians to turn in documentation following a visit was 48 hours and 7 days</p>			

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	<p>for documents to be filed in the patient records.</p> <p>10I. After the entrance conference on 09/15/15 at 12:00 PM, the Administrator was instructed to provide all patient records at once for review. At 12:20 PM, only one record had been provided. The Administrator was observed taking a record to the front reception desk area. At 1:15 PM, the Administrator was interviewed on reason for delay of clinical records. The Administrator stated that she was making sure the charts were complete due to her office manager had quit the previous week and she was behind on filing. On 09/18/15 at 2:00 PM, the Administrator was given the opportunity to provide any missing documentation to the surveyor that was not in the patients record.</p> <p>11I. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "</p>			

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N 0446 Bldg. 00	<p>J. An undated policy titled Administrative Staff indicated, " ... The Administrator's duties shall include but not be limited to the following: Organizes and directs the agency's ongoing functions. Maintains liasion among the Board of Directors, Advisory Committee, and staff. Employs qualified personnel and ensures appropriate staff education and evaluation ... Implements an effective budget and accounting system ... Ensures that the Agency is in compliance with all federal, state, and local regulations related to the delivery of home health care.</p> <p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview, the Administrator failed to ensure test competencies in 4 of 10 individuals employed and annual performance evaluations had been completed in 3 of 10 individuals employed for 2014 - 2015. (#C, D, F, G, and I)</p>	N 0446	N446 The Administrator has ensured that all HomeHealth Aides employed by the agency have completed the written competency testand that the written competency test and skills tests have been filed timelyand appropriately in each Home Health Aide's file. The Administrator has in serviced office staff to ensure properand	10/12/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 10/11/12 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2014. 2. Personnel file D was not provided. 3. Personnel file F evidenced the individual had been hired on 08/26/14 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee. 4. Personnel file G evidenced the individual had been hired on 04/21/14 to provided home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee and an annual performance evaluation had been completed for 2015. 5. Personnel file I evidenced the individual had been hired on 02/09/15 to provide home health aide services on behalf of the agency. The file failed to evidence a written competency test by the employee. 		<p>timely filing of documents in employee files. The Administrator has reviewed the requirements of the Home Health Aide Program with the contractor. The Administrator will ensure that Home Health Aides that are employed by the agency are qualified and competent, have completed the competency evaluation program comprising of the competency skill test and written exam and that the tests are filed timely and appropriately in each Home Health Aide's file. 100% of the Home Health Aide files have been audited to ensure that there is written documentation maintained in each HHA's files to confirm the completion of the program. A monthly audit of 100% of Home Health Aide files will be conducted to ensure that each HHA has completed the competency evaluation program comprising of the competency skills test and written examination and that there is written documentation maintained in each HHA's files to confirm the completion of the program. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. The Administrator has reviewed agency policies on Performance evaluations for employees to ensure that performance reviews are conducted by the appropriate</p>		

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	<p>6. On 09/17/15 at 10:50 AM, employee files were requested to the Administrator. By 12:10 PM, the employee files still were not provided. Upon entering a back office where the Administrator and her Alternate was sitting, Personnel file C was found to be on a table and opened, along with other personnel files on the table. The files were immediately removed from the room. The Administrator had indicated she was making sure that records were complete and correct for review and that loose papers were secured. At 4:30 PM, the Administrator stated Employee D did have a personnel file but she was unable to locate it.</p> <p>7. An undated policy titled Performance Evaluation indicated, "All non-exempt employees shall be evaluated by the appropriate supervisor upon completion of three (3) months of employment, and annually thereafter. Exempt employees shall be evaluated yearly "</p> <p>8. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if</p>		<p>supervisor upon completion of three (3) months of employment and annually thereafter for non-exempt and annually for exempt employees. 100% of employee files have been audited to ensure that three (3) month and the annual performance evaluation for non-exempt and exempt employees have been performed and documented in their employee files. 100% of employee files will be audited quarterly for 4 quarters to ensure that the annual performance reviews for nonexempt and exempt employees have been performed and documented in their employee files. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>The Administrator has evaluated and updated the written contract for the provision of a Registered Nurse to reflect all the services provided by the contractor and ensure that all elements of the contract align with the agency policies including timeliness of submission of clinical records. The Administrator will ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates contracts to reflect all services provided by the contractor and that all elements of the contract</p>		

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N 0456 Bldg. 00	<p>there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the Administrator failed to comply with Indiana State laws and regulation 410</p>	N 0456	<p>align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that contracts have been evaluated annually, and prior to contract renegotiation to identify problems or opportunities for improvement, and determine if contract is to be reviewed or terminated, that contracts are updated to reflect all services provided by the contractor and that all elements of the contract align with the agency policies.</p> <p>The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>N456 The Administrator has reviewed the agency's policies on Quality Assessment and Performance</p>	10/12/2015	

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	<p>IAC 17-2-1(e) in regards to an ongoing quality assurance program that monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care creating the potential to affect all current 9 patients.</p> <p>Findings include:</p> <p>1. 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>2. The Administrator provided a quality improvement binder for first and second quarter review on 09/18/15 at 4:45 PM.</p> <p>a. The first quarter compliance percentage included 485 (Plan of Care) signatures at 100%, Dr. orders at 100%, Medical Professionals with signatures at 60%, Communication Letter / 60 day summaries at 100%, Consents with patient signatures at 100%, and Supervisory visits at 100%. The quality improvement program failed to evidence</p>		<p>Improvement Program.</p> <p>The Administrator will ensure that the agency's Quality Assurance Program complies with the Indiana State laws and regulation by ensuring an ongoing quality assurance program that monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The agency will select indicators to monitor that span the scope of the agency's services using tools that include but are not limited to identified or potential problems (observed or reported), patient surveys or questionnaires and incident reports and a final selection made through prioritization.</p> <p>The Administrator has checked to ensure that the indicators being monitored span the scope of the agency's services and that the data collected for September is well documented, monitors and evaluates the quality and appropriateness of patient care, and the process resolves identified problems and improves patient care. The Administrator will monitor indicators being monitored, data collected monthly and quarterly for four quarters to ensure that the quarterly report summary is well documented, monitors and evaluates the quality and appropriateness of patient care, resolves identified problems and improves patient care. The Administrator is responsible for</p>				

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	<p>quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>b. The second quarter compliance percentage included 485 signatures at 88%, Dr. orders at 100%, Medical Professions with signatures at 100%, Communication letter / 60 day summaries at 100%, Consents with patient signatures at 100%, Supervisory visits at 100%, Assessments with signatures at 77.7%, and Notes with signature dates at 77.7%. The quality improvement program failed to evidence quality and appropriateness of patient care, interventions to problems, patient satisfaction surveys, and infection control.</p> <p>3. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>4. An undated policy titled Quality Assessment and Performance Improvement Program indicated, " ... Objectives: To maintain and improve the highest quality client care and to reduce or eliminate risks and hazards within the client's environment by: [left blank];</p>		<p>monitoring these correctiveactions to ensure that these deficiencies are corrected and will not recur.</p>	

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	Administering and coordinating the Agency's performance improvement program which is designed to ensure all performance improvement activities are implemented. Identifying and prioritizing opportunities to improve client care using ongoing collection and / or screening and evaluating information about outcomes of health care and customer satisfaction. Tracking identified problems to ensure improvement or resolution. Developing and implementing effective performance improvement mechanisms such as monitoring and evaluation committees, incident reporting and trending, and client / physician questionnaires. Documenting the findings, conclusions, recommendations, actions taken, and results of actions taken using defined statistical process. Overseeing the effectiveness of the program and detection of trends, patterns of performance or potential problems that may affect more than one office or department. Improving communication among staff and offices when problems or opportunities to improve client care arises. Ensuring performance based credentialing and competency for each professional and paraprofessional caregiver; identifying marginal or substandard performers for enhanced training or termination as appropriate.			

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	Evaluating at least annually the scope, organization and effectiveness of the performance improvement program ensuring that actions taken are in pursuit of the objectives of this program and within the mission and goals of the Agency. This evaluation is submitted to the Board of Director for review, identifying actual, potential client care problems, evaluating the Agency mechanism for addressing client care problems, identifying the need for revisions in client care services, policies and procedures. Evaluating the adequacy of documentation of client care services. Identifying the extent to which the Agency program is adequate, effective, and efficient in use of all manpower and financial resources. Regularly collecting, aggregating, and analyzing data on staff competency. The agency's quality assessment and performance improvement program consists of but is not limited to the following: Program / staff performance assessment activities. Staff recruitment, training, orientation and continuing education programs, case conferences, management meetings, ongoing review of clinical records, clinical staff peer review activities, clinical record / utilization review, clinical staff competency testing program, review of records requested by peer review, management systems that			

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N 0458 Bldg. 00	<p>support infection control functions, client / physician / staff satisfaction assessment, performance improvement plans, risk management program, sentinel event action plan, performance control activities, and annual program evaluation.</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure that personnel files were current and up to date in relation to current proof of licensure, CPR certification, and annual performance reviews in 2 of 4 home health aide personnel files reviewed. (#C and G) Findings include:</p>	N 0458	N 458 The Administrator has reviewed agency policies on personnel records and performance evaluation. The Administrator has in serviced staff on ensuring that personnel files are current and up to date with all the requirements per policy including current profession of licensure,CPR certification and annual performance reviews. 100% of employee files have been audited and will be audited monthly for 4 quarters to ensure	10/10/2015

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	<p>1. Personnel file C evidenced the individual had been hired on 10/11/12 to provide home health aide services on behalf of the agency. Employee C home health aide certification expired on 10/12/14 and CPR (cardio pulmonary resuscitation) was expired in June 2015. The file failed to evidence a current home health aide registration and CPR, written competency test, and an annual performance evaluation had been completed for 2014.</p> <p>2. Personnel file G evidenced the individual had been hired on 04/21/14 to provided home health aide services on behalf of the agency. The file failed to evidence a current CPR, written competency test, and an annual performance evaluation had been completed for 2015.</p> <p>3. On 09/17/15 at 10:50 AM, employee files were requested to the Administrator. By 12:10 PM, the employee files still were not provided. Upon entering a back office where the Administrator and her Alternate was sitting, Personnel file C was found to be on a table and opened, along with other personnel files on the table. The files were immediately removed from the room. The Administrator had indicated she was making sure that records were complete</p>		that files are kept current and up to date in relation to all required documents including licenses, CPR certification and annual performance reviews for employees and contractors. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	

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	<p>and correct for review and that loose papers were secured.</p> <p>4. An undated policy titled Performance Evaluation indicated, "All non-exempt employees shall be evaluated by the appropriate supervisor upon completion of three (3) months of employment, and annually thereafter. Exempt employees shall be evaluated yearly "</p> <p>5. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>6. An undated policy titled Personnel Records / References indicated, " ... Personnel records shall contain the following ... Receipt of job description. Qualifications. Copy of limited criminal history. Current copy of license, certification or registration. Annual performance evaluations. Application and or resume. Other items and information required by the Agency. Evidence of observed competency skills</p>			

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N 0460 Bldg. 00	<p>check within 90 days of employment if applicable. Copy of valid CPR card for personnel involved indirect patient care ... It shall be the agency's policy that all personnel involved indirect patient care will maintain valid and current CPR certification "</p> <p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the agency failed to ensure all nursing staff had complete and accurate personnel files for 2 of 3 registered nurse personnel files reviewed. Findings include: 1. Personnel file D, an independent contracted Registered Nurse, failed to be</p>	N 0460	N 460 The agency has ensured that all nursing staff and contractors have complete and accurate personnel files including documentation of orientation to job. Annual evaluation and National Criminal background check. 100% of employee and contractor files were audited for September 2015 and will be audited quarterly thereafter, to ensure that allemployees and	10/10/2015

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	<p>evidenced.</p> <p>2. Personnel file E, a resident of the State of Kentucky, failed to evidence a job orientation and a National Criminal Background check.</p> <p>2. On 09/17/15 at 4:30 PM, the Administrator stated Employee D did have a personnel file but she was unable to locate it.</p> <p>3. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "</p> <p>4. An undated policy titled Personnel Records / References indicated, " ... Personnel records shall contain the following ... Receipt of job description. Qualifications. Copy of limited criminal history. Current copy of license, certification or registration. Annual performance evaluations. Application and or resume. Other items and information required by the Agency.</p>		<p>contractors have complete and accurate personnel files. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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N 0470 Bldg. 00	<p>Evidence of observed competency skills check within 90 days of employment if applicable. Copy of valid CPR card for personnel involved indirect patient care ... It shall be the agency's policy that all personnel involved indirect patient care will maintain valid and current CPR certification "</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 2 of 4 home visit observations. (#1 and 2)</p> <p>Findings include:</p> <p>1. An undated policy titled OSHA Regulations / Infection Control / Exposure Control Plan policy indicated, "The agency shall maintain policies and procedures for ... infection control practices by employees which conform with OSHA regulations and currently accepted standards of care "</p>	N 0470	<p>N 470 The Supervising Registered Nurse has inserviced the Registered Nurses and all field staff on providing care in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Registered Nurse(Employee B) has completed additional in services on hand washing, and infection control. The Supervising Registered Nurse has made weekly unannounced visits for 2 weeks to observe Employee B during dressing changes and will make monthly unannounced visits thereafter for 3 quarters to ensure that care is provide in accordance with the agency's Infection Control policies and procedures</p>	10/06/2015			

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	<p>2. An undated policy titled Bloodborne Pathogens indicated, "Universal precautions will be maintained during the performance of agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves "</p> <p>3. An undated policy titled Infection Control Program indicated, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives ... To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines "</p> <p>4. The Centers for Disease Control Standard Precautions indicated, "IV. Standard Precautions ... IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's</p>		<p>and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse has made an unannounced visit and will make monthly unannounced visits for one quarter and quarterly thereafter to observe each field staff providing care, to ensure that care is provided in accordance with the agency's Infection Control policies and procedures and the Center for Disease and Control "Standard Precautions." The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves ... IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently ... IV.B. Personal protective equipment (PPE) ... IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin ... could occur. "</p> <p>5. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was observed providing wound care to the patient's left ischium and coccyx wounds. Employee B was observed to don gloves after hand cleaning and remove the patient's soiled dressing, remove gloves and don new gloves, failing to wash</p>			

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	hands or use hand sanitizer. Employee B then moistened a 4 x 4 gauze and proceeded to clean the left ischium wound with a Q-tip then moistened another 4 x 4 gauze and proceeded to clean the coccyx wound with a Q-tip, failing to change gloves and clean her hands in between wound sites. Employee B continued to pour saline in a package and cleaned the left ischium again with Q-tips then took the moistened 4 x 4 gauze and cleaned the patient's groin, then obtained another 4 x 4 gauze and cleaned the coccyx skin area, moving to cleaning the skin around both wounds, failing to change gloves and clean hands between tasks. After the cleaning, Employee B removed her gloves at that time and reapplied gloves without washing hands or sanitizing them. Employee B proceeded to apply santyl ointment (debriding agent that dissolves dead tissue in a wound) to a Q-tip and placed the Q-tip in the wound cavity to apply to dead tissue, then took the same Q-tip and applied more santyl to the tip and placed back in the wound bed, failing to change Q-tips with each application. Employee B continued to obtain another Q-tip and applied santyl to the tip and proceeded to apply ointment to the coccyx wound, failing to change gloves and clean hands between wounds. Employee B then obtained a new Q-tip and applied calmoseptine (skin barrier) to			

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	<p>it and proceeded to apply the cream around the edges of the left ischium wound and coccyx wound and well as the surrounding skin, using the same Q-tip, failing to change Q-tips for new area of application. Using the same gloves and Q-tip, Employee B opened another packet of 4 x 4 and placed it in the left ischium and coccyx, then took a roll of kerlix gauze and cut a strip off the roll and began to pack the left ischium wound then again to the coccyx wound, applied 1 skin prep pap (skin barrier) around the skin, placed an ABD pad over both wounds and secured with tape, failing to change gloves and clean hands between wounds packing of wounds and application of skin treatment. Employee B then removed her gloves and reapplied new gloves and removed a disposable pad from underneath the patient, failing to clean her hands in between glove changes. Employee B then removed her gloves, obtained her blood pressure machine from her nursing bag, and placed the patient's wrist. Employee B returned to her nursing bag and obtained a thermometer and placed it into the patient's mouth, failing to clean hands after gloves removal.</p> <p>6. A home visit was made to patient #2 with Employee B, a registered nurse, on 09/16/15 at 9:00 AM. Employee B, was</p>			

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N 0478 Bldg. 00	<p>observed providing wound care to patient #2. After doning gloves, Employee B proceeded to clean a wound located to the left outer / lower leg then placed a piece of paper over the wound and traced the wound for measurement. Employee B proceeded to use same piece of paper and traced wounds to the right / lower shin, right / upper shin, right forearm. Employee B cleaned each wound with a new gauze but failed to change gloves and clean hands between each cleaning. Employee B then began checking for pedal pulses in both feet, removed gloves, don new gloves and applied new dressings to all wounds, without cleaning her hands in between glove changes.</p> <p>7. The Administrator was interviewed on 09/18/15 at 4:30 PM. The Administrator had indicated that she and Employee B had just recently reviewed infection control recently.</p> <p>410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all</p>			

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	<p>applicable home health agency policies including personnel qualifications.</p> <p>(4) The responsibility for participating in developing plans of care.</p> <p>(5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency.</p> <p>(6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation.</p> <p>(7) The procedures for payment for services furnished under the contract.</p> <p>Based on record review and interview, the Administrator failed to update a written contract for the provision of a Registered Nurse for 1 of 2 contracts reviewed.</p> <p>Findings include:</p> <p>1. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator had stated that clinical visit notes were to be in the office within 48 hours following a visit.</p> <p>2. During a home visit on 09/15/15 at 4:30 PM, Employee D, a Registered Nurse, was observed providing an Intravenous Infusion and assessment to patient #1.</p> <p>3. Review of Employee D contract dated 07/09/10, the contract indicated Employee D was to provide only Inservice Training and testing of home</p>	N 0478	<p>N478 The Administrator has updated the written contract for the provision of a Registered Nurse, and reviewed agency policies on contracts to ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates contracts to reflect all services provided by the contractor and that all elements of the contract align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that all contracts are updated to accurately reflect all contracted services in all the appropriate sections of the contract and that all elements of the contract align with the agency policy including timeliness of turning in paper work. The Administrator is responsible for monitoring these corrective actions to ensure that</p>	10/10/2015

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	<p>health aides for home health aide competency evaluation program and consultation. The contract also indicated, "Contractor agrees to submit documentation of the services provided in accordance with the record keeping requirements of Agency ... on a bi-weekly basis on the MOnday of each pay period week prior to 10:00 AM "</p> <p>4. The Administrator was interviewed on 09/17/15 at 3:00 PM. The Administrator stated on page 8 of the contract, she had indicated reimbursement for skilled follow up visit and thought that was sufficient to allow Employee D to see patients. The Administrator did not have any further information regarding the timeliness of turning in paperwork.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less often than every 60 days "</p> <p>6. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner</p>		<p>thesedeficiencies are corrected and will not recur The Supervising Registered Nurse has in serviced professional staff on reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days. 100% of patient charts have been audited and will be audited quarterly for four quarters to ensure that careplans are reviewed and updated on an ongoing basis within 5 days of identifying the change but no less than every 60 days.</p> <p>The Supervising Registered Nurse is responsible for monitoring the correctiveaction on care plans to ensure that the deficiency is corrected and will not recur The Administrator has in servicedhealthcare professionals on maintaining the clinical record in such a mannerthat it is current, assembled and filed in a timely manner in accordance withlaw and regulation. 100% of patient charts were audited by 10/06/2015 and willbe audited quarterly thereafter to ensure that all is assembled and filed in atimely manner and in accordance with law and regulation. The Administrator is responsible for monitoring these corrective actionsto ensure that these deficiencies are corrected and will not recur.</p> <p>The Administrator has evaluated and updatedthe written contract</p>				

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N 0484 Bldg. 00	and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... " 7. An undated policy titled Contract Staff Evaluation indicated, "Services are evaluated annually to validate and maintain high performance contract services. The evaluations are performed by the Agency at least annually and prior to the contract renegotiation process to help the Agency's leadership determine if there are problems or opportunities for improvement and if the contract is to be revised, renewed or terminated "		for the provision of a Registered Nurse to reflect all the services provided by the contractor and ensure that all elements of the contract align with the agency policies including timeliness of submission of clinical records. The Administrator will ensure that the agency conducts contract evaluations at least annually and prior to contract renegotiation to identify problems or opportunities for improvement, updates contracts to reflect all services provided by the contractor and that all elements of the contract align with the agency policies, and determine if contract is to be reviewed or terminated. 100% of contracts have been audited and will be audited quarterly for 4 quarters to ensure that contracts have been evaluated annually, and prior to contract renegotiation to identify problems or opportunities for improvement, and determine if contract is to be reviewed or terminated, that contracts are updated to reflect all services provided by the contractor and that all elements of the contract align with the agency policies. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.		

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	<p>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 observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to</p>	N 0484	N484 The Administrator has in servicedprofessional staff on coordination of services for all patients with otherdisciplines and other outside services that are furnishing the patient withservices and documenting the coordination of services effectively in thepatient's clinical record. Case conferences involving disciplines providingservices for patients have been held and documented in the Coordination of caresummary, as well as care coordination with outside agencies as ordered in thecare plan by the physician and documented in the communication notes. The Administrator has in serviced professional staff on the effectivecoordination of services for all patients by all disciplines providing servicesand with other outside services, holding case conferences as well as effectivedocumentation of coordinated services in the Coordination of care summaryrecord and making the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will beaudited quarterly for 4 quarters to ensure	10/10/2015

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	<p>coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p>		<p>that staff efforts are coordinated and documented effectively with all disciplines providing services and with other outside services that are furnishing services. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for</p>			

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	<p>skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10. An undated policy titled Physical</p>			

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N 0486 Bldg. 00	<p>Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>12. An undated policy titled Coordination of Care indicated, "The agency shall coordinate the care of all patients under the agency's services. All personnel providing services to patients shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The method of communication and results shall be documented in the clinical record and or coordination of care summary record during case conferences. The records shall be a part of the clinical record. The agency shall coordinate its services with other health providers serving the patient."</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 patient. Based on observation, clinical record and</p>	N 0486	N486 The Administrator has in servicedprofessional staff on	10/10/2015

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	<p>policy review and interview, the agency failed to ensure their efforts were coordinated effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date</p>		<p>coordination of services for all patients with other disciplines and other outside services that are furnishing the patient with services and documenting the coordination of services effectively in the patient's clinical record. Case conferences involving disciplines providing services for patients have been held and documented in the Coordination of care summary, as well as care coordination with outside agencies as ordered in the care plan by the physician and documented in the communication notes. The Administrator has in serviced professional staff on the effective coordination of services for all patients by all disciplines providing services and with other outside services, holding case conferences as well as effective documentation of coordinated services in the Coordination of care summary record and making the documents a part of the patient's clinical record.</p> <p>100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that staff efforts are coordinated and documented effectively with all disciplines providing services and with other outside services that are furnishing services. The Administrator is responsible for monitoring this corrective action to ensure that</p>	

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	<p>06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a</p>		this deficiency is corrected and will not recur.		

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	<p>council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to</p>			

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	<p>evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall</p>			

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N 0504 Bldg. 00	<p>include but not limited to ... Participation in case conferences ... "</p> <p>12. An undated policy titled Coordination of Care indicated, "The agency shall coordinate the care of all patients under the agency's services. All personnel providing services to patients shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The method of communication and results shall be documented in the clinical record and or coordination of care summary record during case conferences. The records shall be a part of the clinical record. The agency shall coordinate its services with other health providers serving the patient."</p> <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. Based on record review and interview,</p>	N 0504	N 504 Admission service agreements have been updated	10/06/2015

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	<p>the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 4 of 9 records reviewed. (#2, 7, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, SOC (start of care) 12/15/14. The Admission Service Agreement dated 12/15/14, indicated the patient was to receive home health aide services for bathing and ADLs (activities of daily living). The Admission Service Agreement failed to evidence the frequency of the proposed visits. 2. Clinical record #7, SOC 01/13/15. The Admission Service Agreement dated 01/13/15, indicated the patient were to receive home health aide services three times a week and homemaker services two times a week. The "Planned Treatment" was left blank. The Admission Service Agreement failed to evidence the scope of services that was to be provided by the home health aide and homemaker. The Admission Service Agreement failed to evidence the length of services to be provided. 3. Clinical record #8, SOC 07/30/15. The Admission Service Agreement dated 		<p>and provided to patients stating disciplines that will furnish care, type of care to be provided, frequency and duration of the proposed visits, as well as verbal explanations to the patients. The Supervising Registered Nurse has in serviced all Registered Nurses on admission and as often as needed of the disciplines that will furnish care, type of care to be furnished, changes in the care to be furnished, frequency and duration of the proposed visits. 100% of patient charts were audited on 10/ 10/2015 and will be audited quarterly for 4 quarters to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, frequency and duration of the proposed visits, as well as verbal explanations to the patients. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	

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	<p>01/13/15, indicated the patient were to receive physical therapy and occupational therapy. The Admission Service Agreement failed to evidence the frequency proposed and plan of treatment for physical and occupational therapy.</p> <p>4. Clinical record #9, SOC 04/13/15. The Admission Service Agreement dated 04/13/15, indicated the patient was to receive skilled nursing three times a week for "assessment, medication administration per 485." The Admission Service Agreement failed to specify in terms that the patient can understand (485) for planned treatment and failed to specify duration of services to be provided.</p> <p>5. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>6. An undated policy titled Client Rights indicated, " ... The client has the right to be informed about the care to be furnished, and of any changes in the care to be furnished ... "</p> <p>7. An undated policy titled Informed Consent indicated, "An informed consent will be explained to and signed by all</p>			

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N 0518 Bldg. 00	<p>clients or the client's legal representative prior to admission. Explanation of the informed consent ensures that all client / families are informed about the type of care and services provided during the course of illness and that the client / family consent to such ... "</p> <p>8. An undated policy titled Client Rights / Responsibilities indicated, " ... On admission and as often as necessary, verbally and in writing, client and Agency responsibilities for care and services including the cost of care and any financial responsibility of the client related to the care / services provided by the Agency will be provided to the client / caregiver(s) ... "</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. Based on observation, record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced</p>	N 0518	N518 The Supervising Registered Nurse has updated all Admissionpackets with the current July 2013 version of the 2004 Indiana AdvancedDirectives	10/06/2015	

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	<p>Directives, including a description of applicable State law, in 9 of 9 clinical records reviewed (#1 - 9).</p> <p>Findings</p> <p>1. The admission folder that are provided to patients was reviewed on 09/15/15. The admission folder failed to include an updated July 2013 version of the 2004 Indiana Advanced Directives document as well as the agency policy.</p> <p>2. Interview on 9/18/15 at 4:45 PM, the Administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. Clinical record #1, SOC (start of care) date 11/27/13, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>4. Clinical record #2, SOC date 12/15/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p> <p>5. Clinical record #3, SOC date 06/24/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.</p>		<p>as well as the agency's policy on Advance Directives. All patients have received the updated July 2013 version of the 2004 Indiana Advanced Directives as well as the agency Policy on Advance Directives. The Supervising Registered Nurse will perform monthly audits on 100% of patient charts for three quarters to ensure that the Admission packet provided to patients, contain a copy of the agency's policy on advanced Directives and that the Advance Directives brochure distributed to patients is the effective and current advanced directives (effective May 2004 and revised July 1, 2013). The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	6. Clinical record #4, SOC date 09/29/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advanced Directives document.			
	7. Clinical record #5, SOC date 09/25/12, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.			
	8. Clinical record #6, SOC date 02/13/14, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.			
	7. Clinical record #7, SOC date 01/13/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.			
	8. Clinical record #8, SOC date 07/30/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.			
	9. Clinical record #9, SOC date 04/13/15, failed to receive the updated July 1, 2013, version of the 2004 Indiana Advance Directives document.			
	10. The Administrator was interviewed on 09/17/15 at 12:30 PM. The Administrator stated patient #2 had			

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N 0522 Bldg. 00	<p>known what his / her payor source was and the patient was receiving Medicare, Medicaid, and Medicare services.</p> <p>11. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings in the records referenced above.</p> <p>12. An undated policy titled Client Rights indicated, " ... The agency shall inform and distribute written information to the client, in advance, concerning its policies on advance directives, including a description of applicable State Law. The agency shall furnish advanced directives information to a client at the time of the first home visit before care is provided ... "</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 and policy review and interview, the agency failed to ensure visits had been provided and nursing assessments provided only as ordered by the physician per plan of care in 9 of 10 records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8, and 9)</p>	N 0522	N522 The Supervising Registered Nurse has inserviced all healthcare personnel on providing care and services consistent with the plan of care ordered by the physician. 100% of the patient's charts were audited on 10/12/2015, and care had been provided and services consistent	10/12/2015			

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	<p>Findings include:</p> <p>1. Clinical record #1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15, with orders for skilled nursing visits were to be provided two times a week for 9 weeks. Review of the skilled nursing visit notes, the record failed to evidence a second visit during week one, two, three, four, six, seven, and eight. The skilled nurse failed to follow the plan of care.</p> <p>2. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing visits to be provided two time a week for one week, three times a week for one week, four times a week for one week, three times a week for four weeks, four times a week for one week, and three times a week for one week. Review of the skilled nursing visit notes on 09/15/15 at 1:30 PM, the record failed to evidence a fourth visit during week three. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record #3, SOC 12/15/14, included a plan of care established by the physician for the certification period</p>		<p>with the plan of care ordered by the physician. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks.</p> <p>a. During a home visit on 09/16/15 at 8:00 AM, the patient had stated that the agency sometimes have problems staffing home health aides for both times of the day. The patient stated getting her two visits in would depend on what home health aide was working on that particular day.</p> <p>b. Review of the home health aide visit notes on 09/15/15 at 2:45 PM, the record failed to evidence a second visit was made on 08/31/15 to 09/02/15 and 08/07/15 to 09/09/15. The home health aide failed to follow the plan of care.</p> <p>c. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>4. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing one time every other week for 8 weeks for supervision, case management, assessment and home health aide services 7 days a week for 8 weeks then four days a week for one</p>						

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	<p>week.</p> <p>a. Review of the skilled nursing notes failed to evidence nursing assessments and case management every other week. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period on 07/27, 07/28, 07/30, 08/04, 08/06, 08/07, 08/13, 08/18, 08/20, 08/21, 08/23, 08/25, 09/01, 09/23/15. The record also failed to evidence that a home health aide visit was made on 08/29/15. The home health aide failed to follow the plan of care.</p> <p>c. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>5. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services four times a week for two weeks then two times a week for one week.</p> <p>a. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period, twice a</p>				

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	<p>week during week 1, 2, 3, 4, 5, 6, 8, and made two visits on 08/25/15 during week 7. The home health aide failed to follow the plan of care.</p> <p>b. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days.</p> <p>6. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for skilled nursing one every two weeks for 8 weeks then one time a week for one week for recertification and attendant care services one time a week for one week, 5 times a week for 8 weeks, then one time a week for one week.</p> <p>a. The plan of care indicated the skilled nurse was to assess cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p> <p>b. A signed physician order dated 08/20/15, indicated to discontinue attendant care services and to start home health aide services two times a week for</p>			

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	<p>one week, 5 times a week for 6 weeks, then one time a week for one week.</p> <p>Review of the attendant care and home health aide visit notes, the attendant care continued to see the patient on 08/22 and 08/23/15. The home health aide made his / her first visit on 08/24/15. The attendant care and home health aide failed to follow the plan of care.</p> <p>c. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>7. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing one time every two weeks for 8 weeks, home health aide services three times a week for 8 weeks then two times a week for one week and homemaker services two times a week for 9 weeks.</p> <p>a. Review of the plan of care indicated the skilled nurse was to assess the cardiovascular, integumentary, musculoskeletal,</p>			

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	<p>respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes, the clinical record failed to evidence that visits were made between 07/12/15 to 08/17/15. The home health aide failed to follow the plan of care.</p> <p>c. Review of the homemaker visit notes, the clinical record evidenced that two extra visits (total of 4 visits) were made between 08/25/15 to 08/28/15. The homemaker failed to follow the plan of care.</p> <p>8. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing one time a week for one week, two times a week for one week, then one times a week for 7 weeks, home health aide services one time a week for one week then three times a week for 8 weeks, occupational therapy one time a week for one week, two times a week for two weeks, then one time a week for one week.</p> <p>a. Review of the skilled nursing visit notes, the clinical record failed to</p>			

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	<p>evidence that a second visit was provided during week two. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the home health aide visit notes, the clinical record failed to evidence that two visits were made during week two. The home health aide failed to follow the plan of care.</p> <p>c. Review of the occupational therapy notes, the clinical record failed to evidence that two visits were made during week two. The occupational therapist failed to follow the plan of care.</p> <p>d. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued and homemaker services would start the week of 08/09/15, three times a week for 7 weeks. Review of the homemaker visit notes, the clinical record failed to evidence that two visits were made during week 5, three visits were made during week 6, one visit was made during week 7, and three visits were made during week 8. The homemaker failed to follow the plan of care.</p> <p>9. Clinical record #9, SOC 04/13/15, included a plan of care established by the physician for the certification period 08/01/15 to 09/29/15 with orders for</p>			

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N 0524 Bldg. 00	<p>skilled nursing four times a week for 8 weeks then two times a week for 1 one starting the week of 08/02/15. Review of the skilled nursing visit notes, the clinical record failed to evidence a fourth visit was made during week two and three visits were made during week three. The skilled nurse failed to follow the plan of care.</p> <p>10. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The Agency will provide care / services consistent with the plan of care ... "</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.</p>			

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	<p>(iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on observation, clinical record and policy review and interview, the agency failed to ensure plans of care were revised that included all medications for 3 of 9 records reviewed. (#1, 2, and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15.</p> <p>a. Line 21 (Orders for Discipline and Treatments) of the Plan of care indicated the patient was to receive Benedryl 25 mg (milligrams) via g/tube (gastrostomy tube) 30 to 60 minutes prior to infusion, Emla cream or LMX4 (numbing agent) cream one hour prior to accessing port, infuse Elaprase 24 mg via port a cath [catheter] once a week, dilute Elaprase in 0.9 Sodium chloride in 100 ml (milliliter)</p>	N 0524	N524 The Supervising Registered Nurse hasin serviced staff on reviewing care plans on an ongoing basis but no less oftenthan 60 days and update the care plan to reflect the change, include but notlimit care plan to specific discipline, frequent duration of services,medication orders for treatment and notifying physician immediately of any changein the client's condition which indicate changes to the plan of treatment. 100% of patient charts were audited on 10/12/2015 to ensurethat care plans have been reviewed and updated and were found to be incompliance. 80% of patient charts will be audited monthly for two months andquarterly thereafter for three quarters to ensure that care plans have beenreviewed and updated no less often than 60 days and that care plans include butare not limited to specific discipline, frequency and duration of	10/12/2015	

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	<p>bag, flush IV [intravenous] line with normal saline and heparin, give Epinephrine 0.01 mg per kilogram for severe reaction to medication. The Medication profile failed to indicate the medications listed and the strength of the normal saline and heparin flushes.</p> <p>b. Line 21 also indicated "SN [skilled nurse] to follow all medication protocol per [Name of Pharmacy]. The plan of care failed to indicate what the medication protocol specific to the medication was.</p> <p>2. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks. The plan of care failed to be updated and specific to include the the amount of visits per day and the length of time per visit specific to the payer source.</p> <p>a. Review of the recertification follow up assessment dated 08/27/15, indicated the registered nurse had been applying nystatin cream to the reddened areas in the patient's abdominal folds. The medication section of the plan of care failed to include the nystatin cream, strength, and instructions.</p>		<p>service, medication orders for treatment and notifying physician immediately of any change in the client's condition which indicate changes to the plan of treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>b. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. The plan of care failed to include coordination of services with the wound center.</p> <p>3. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Two recertification / follow up assessments dated 07/10/15 and 09/08/15, indicated the patient was receiving IV infusions twice a week from an outside agency. The plan of care failed to be updated to include the IV medication and failed to be updated to include that the patient was receiving skilled nursing, physical and occupational therapy from an outside agency.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of identification of a change, but no less</p>			

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N 0537 Bldg. 00	<p>often than every 60 days "</p> <p>6. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The plan of care shall include but not be limited to ... Specific discipline, frequency and duration of services ... Medications ... Orders for treatments ... The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment "</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and policy review and interview, skilled nursing failed to ensure visits, assessments, and care coordination was provided per the plan of care 9 of 9 records reviewed. (#1 - 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15, that identified skilled nursing visits were</p>	N 0537	N537 The Supervising Registered Nurse has inserviced all healthcare personnel on providing care and services consistent with the plan of care. 100% of the patient's charts will be audited monthly for two months and quarterly thereafter to ensure that care provided is consistent with the plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/12/2015

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	<p>to be provided two times a week for 9 weeks. Review of the skilled nursing visit notes, the clinical record failed to evidence a second visit during week one, two, three, four, six, seven, and eight. The skilled nurse failed to follow the plan of care.</p> <p>2. Clinical record #2, SOC 12/15/14, included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing visits to be provided two time a week for one week, three times a week for one week, four times a week for one week, three times a week for four weeks, four times a week for one week, and three times a week for one week. Review of the skilled nursing visit notes, the clinical record failed to evidence a fourth visit during week three. The skilled nurse failed to follow the plan of care.</p> <p>3. Clinical record #3, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p>			

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	<p>4. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing one time every other week for 8 weeks for supervision, case management, assessment.</p> <p>a. Review of the skilled nursing notes failed to evidence nursing assessments and case management every other week. The skilled nurse failed to follow the plan of care.</p> <p>b. The plan of care indicated that patient also had services with a council on aging agency and care coordination was to be done every 60 days. This skilled nurse failed to follow the plan of care.</p> <p>5. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>6. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period</p>			

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	<p>08/07/15 to 10/05/15, with orders for skilled nursing one every two weeks for 8 weeks then one time a week for one week for recertification.</p> <p>a. The plan of care indicated the skilled nurse was to assess cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse failed to follow the plan of care.</p> <p>b. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The skilled nurse failed to follow the plan of care.</p> <p>7. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing one time every two weeks for 8 weeks. Review of the plan of care indicated the skilled nurse was to assess the cardiovascular, integumentary, musculoskeletal, respiratory, neurological status, and entire body system, as well as pain control at each visit. The skilled nurse</p>				

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	<p>failed to follow the plan of care.</p> <p>8. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing one time a week for one week. Review of the skilled nursing visit notes, the clinical record failed to evidence a second visit during week two. The skilled nurse failed to follow the plan of care.</p> <p>9. Clinical record #9, SOC 04/13/15, included a plan of care established by the physician for the certification period 08/01/15 to 09/29/15 with orders for skilled nursing four times a week for 8 weeks then two times a week for 1 one starting the week of 08/02/15. Review of the skilled nursing visit notes, the clinical record failed to evidence a fourth visit during week two and three visits during week three. The skilled nurse failed to follow the plan of care.</p> <p>10. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11. An undated policy titled Physician's Plan of Treatment (Care) / Change</p>			

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N 0542 Bldg. 00	<p>Orders indicated, " ... The Agency will provide care / services consistent with the plan of care ... "</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on observation, clinical record and policy review and interview, the agency failed to ensure plans of care were revised that included all medications for 3 of 9 records reviewed. (#1, 2, and 7)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/27/13, included a plan of care established by the physician for the certification period 07/20/15 to 09/17/15.</p> <p>a. Line 21 (Orders for Discipline and Treatments) of the Plan of care indicated the patient was to receive Benedryl 25 mg (milligrams) via g/tube (gastrostomy tube) 30 to 60 minutes prior to infusion, Emla cream or LMX4 (numbing agent) cream one hour prior to accessing port, infuse Elaprase 24 mg via port a cath [catheter] once a week, dilute Elaprase in</p>	N 0542	N 542 TheSupervising Registered Nurse has in serviced all Registered Nurses on providingcare and services consistent with the plan of care by ensuring that plans ofcare are reviewed and updated on an ongoing basis and within 5 days ofidentification of a change but no less often than every 60 days. RegisteredNurses are to ensure that plans of care include but are not limited to specificdiscipline, frequency, and duration of services, medications and orders fortreatment, 100% of the patient's charts will be auditedmonthly for two months and quarterly thereafter to ensure that care provided isconsistent with the plan of care established by the physician, and that plansof care are reviewed and updated on an ongoing basis and within 5 days ofidentification of a change but no less often than every 60 days. The Supervising Registered	10/12/2015

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	<p>0.9 Sodium chloride in 100 ml (milliliter) bag, flush IV [intravenous] line with normal saline and heparin, give Epinephrine 0.01 mg per kilogram for severe reaction to medication. The Medication profile failed to indicate the medications listed and the strength of the normal saline and heparin flushes.</p> <p>b. Line 21 also indicated "SN [skilled nurse] to follow all medication protocol per [Name of Pharmacy]. The plan of care failed to indicate what the medication protocol specific to the medication was.</p> <p>2. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks. The plan of care failed to be updated and specific to include the the amount of visits per day and the length of time per visit specific to the payer source.</p> <p>a. Review of the recertification follow up assessment dated 08/27/15, indicated the registered nurse had been applying nystatin cream to the reddened areas in the patient's abdominal folds. The medication section of the plan of care failed to include the nystatin cream,</p>		Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.				

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	<p>strength, and instructions.</p> <p>b. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. The plan of care failed to include coordination of services with the wound center.</p> <p>3. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15. Two recertification / follow up assessments dated 07/10/15 and 09/08/15, indicated the patient was receiving IV infusions twice a week from an outside agency. The plan of care failed to be updated to include the IV medication and failed to be updated to include that the patient was receiving skilled nursing, physical and occupational therapy from an outside agency.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Professional / Ancillary Care Plans indicated, " ... Careplans will be reviewed and updated on an ongoing basis and within 5 days of</p>			

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N 0545 Bldg. 00	<p>identification of a change, but no less often than every 60 days "</p> <p>6. An undated policy titled Physician's Plan of Treatment (Care) / Change Orders indicated, " ... The plan of care shall include but not be limited to ... Specific discipline, frequency and duration of services ... Medications ... Orders for treatments ... The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment "</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with all disciplines providing services and with other outside services that were furnishing services for 7 of 9 records reviewed. (#2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #2, SOC 12/15/14,</p>	N 0545	<p>N 545 The Administrator has in serviced staff and contractors on the coordination of services for all patients by all disciplines providing services and with other outside services furnishing services. All staff providing services to patient are to participate in the Case conferences and effectively document case conference in the Coordination of care summary and use Communication notes to document coordination with</p>	10/10/2015

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	<p>included a plan of care established by the physician for the certification period of 08/12/15 to 10/10/15, with orders for skilled nursing to provide wound care to the patient's ischium and sacral wounds.</p> <p>a. During a home visit with the patient on 09/16/15 at 8:00 AM, the patient stated that she goes to a wound care center on a routine bases. Review of the clinical record failed to evidence coordination of services with the wound care center.</p> <p>b. Review of the plan of care indicated skilled nursing was to coordinate services with SWIRCA providing case management services every 60 days. The clinical record failed to evidence that services were coordinated effectively.</p> <p>2. Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively.</p> <p>3. Clinical record #4, SOC 09/24/14, included a plan of care established by the</p>		<p>outside services furnishing services topatient and make the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will beaudited quarterly for 4 quarters to ensure that agency efforts are coordinated anddocumented effectively in the patient's chart by all disciplines providingservices and with other outside services furnishing services to the patient. The Administrator is responsible for monitoring this correctiveaction to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>physician for the certification period 07/26/15 to 09/23/15 with orders for skilled nursing and home health aide services. Review of the clinical record indicated that the patient was receiving home health aide services from another agency four hours a day, two times a week. The plan of care indicated that patient also has services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>4. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15 with orders for skilled nursing and home health aide services. Review of the plan of care indicated that patient had services with a council on aging agency and care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>5. Clinical record #6, SOC 02/13/14, included a plan of care established by the physician for the certification period 08/07/15 to 10/05/15, with orders for</p>				

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	<p>skilled nursing and attendant care services. Review of the plan of care indicated that the patient had services with a council on aging agency and was attending adult day care services. The plan of care indicated that care coordination was to be done every 60 days. The clinical record failed to evidence that the agency coordinated their services effectively with both outside service agencies.</p> <p>6. Clinical record #7, SOC 01/13/15, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for skilled nursing, home health aide and homemaker services. Review of a skilled nursing note dated 09/08/15, indicated the patient was receiving skilled nursing for IV [intravenous] therapy, physical and occupational therapy through an outside service. The clinical record failed to evidence that the agency coordinated their services effectively with the outside service agency.</p> <p>7. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to</p>			

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	<p>evidence that all disciplines coordinated their services effectively.</p> <p>8. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>9. An undated policy titled Skilled Nursing Services, " ... Profession nursing services shall be performed ... Coordination of total client care ... Participation in case conferences ... "</p> <p>10. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>11. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>12. An undated policy titled Case Conferencing indicated, " ... Case conferences shall be held regularly to review problem cases and to review the plan of treatment for appropriateness and feasibility of continued services. Such conferences shall be documented separately or in the clinical record and</p>				

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N 0550 Bldg. 00	<p>should be held on each client at the time of admission, prior to the date of the plan of treatment is due for the review and prior to discharge "</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the Registered Nurse failed to establish two written patient care instructions for the home health aides who provided care in the morning and evening for 3 of 7 records reviewed with home health aide services. (#2, 4, and 5).</p> <p>Finding include:</p> <p>1. Clinical record number 2, SOC 12/15/14, included a plan of care established by the physician for the certification period 08/12/15 to 10/10/15, with orders for home health aide 8 times for one week then 14 times for 8 weeks.</p> <p>Review of the home health aide visit notes, the home health aide made two visits (morning and afternoon) to the</p>	N 0550	N 550 The Supervising Registered Nurse hasin serviced Registered Nurses on establishing a two-three written patient care instructions for Home Health Aides to match the number of dailyvisits ordered by the physician. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that the applicable writtenpatient care instructions are in all applicable patient charts. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/10/2015

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	<p>patient's home from 08/12/15 to 08/26, 08/28/15, 08/30/15, 09/03/15 to 09/06/15, and three visits on 08/27/15 and 08/29/15. Upon review of the home health aide written plan of care, only one written plan of care was established for the home health aide for all visits. The clinical record failed to evidence a two - three written patient care instructions for each time of the day.</p> <p>2. Clinical record #4, SOC 09/24/14, included a plan of care established by the physician for the certification period 07/26/15 to 09/23/15 with orders for home health aide services 7 days a week for 8 weeks then four days a week for one week.</p> <p>Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period on 07/27, 07/28, 07/30, 08/04, 08/06, 08/07, 08/13, 08/18, 08/20, 08/21, 08/23, 08/25, 09/01, 09/23/15. The clinical record failed to evidence a two written patient care instructions for each time of the day.</p> <p>3. Clinical record #5, SOC 09/25/12, included a plan of care established by the physician for the certification period 07/12/15 to 09/09/15, with orders for home health aide services four times a week for two weeks then two times a</p>			

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N 0565 Bldg. 00	<p>week for one week. Review of the home health aide visit notes, the home health aide made two visits in a 24 hour period, twice a week during week 1, 2, 3, 4, 5, 6, 8, and made two visits on 08/25/15 during week 7. The clinical record failed to evidence a two written patient care instructions for each time of the day.</p> <p>4. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>5. An undated policy titled Home Health Aide Services indicated, " The Agency shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist ... Home Health aide services shall include but not be limited to: Assisting the client to maintain personal hygiene. Assisting the client with ambulation as appropriate. Planning and preparing meals. Maintaining a health, safety environment "</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:</p>						

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	<p>(4) help develop the plan of care (revising as necessary); Based on observation, clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated and documented effectively with all disciplines providing services in 2 of 2 records reviewed receiving therapy services. (#3 and 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #3, SOC date 06/24/15, included a plan of care established by the physician for the certification period of 06/24/15 to 08/22/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for skilled nursing, home health aide services, physical and occupational therapy. The clinical record failed to evidence that all disciplines coordinated their services effectively. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to 	N 0565	<p>N565 The Administrator has in serviced staff and contractors on the coordination of services for all patients by all disciplines providing services and with other outside services furnishing services. All staff providing services to patient are to participate in the Case conferences and effectively document case conference in the Coordination of care summary and use Communication notes to document coordination with outside services furnishing services to patient and make the documents a part of the patient's clinical record. 100% of patient charts were audited on 10/10/2015 and will be audited quarterly for 4 quarters to ensure that agency efforts are coordinated and documented effectively in the patient's chart by all disciplines providing services and with other outside services furnishing services to the patient. The Administrator is responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	10/10/2015			

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N 0566 Bldg. 00	<p>provide any further documentation and / or information regarding the findings referenced above.</p> <p>4. An undated policy titled Physical Therapy indicated, " ... Physical therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>5. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Participation in case conferences ... "</p> <p>410 IAC 17-14-1(c)(5) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; Based on clinical record review and interview, the occupational therapist failed to complete an assessment upon discharge for 1 of 2 record reviewed receiving therapy services. (#8)</p> <p>Findings include:</p> <p>1. Clinical record #8, SOC 07/30/15, included a plan of care established by the physician for the certification period 07/30/15 to 09/27/15 with orders for occupational therapy.</p>	N 0566	N566 The Supervising Registered Nurse has inserviced therapists on completing discharge assessments for patients upon discharge. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly to ensure that discharge assessments have been completed for all patients discharged from therapy services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The	10/12/2015

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N 0602 Bldg. 00	<p>a. Review of the physician orders, a signed order dated 08/06/15, indicated that Medicare services were to be discontinued.</p> <p>b. Review of the occupational therapy notes, the occupational therapist failed to complete a discharge assessment.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>3. An undated policy titled Occupational Therapy indicated, " ... Occupational therapy services shall include but not limited to ... Assessment and reassessment of the client and evaluation of the client's level of function ... documentation of clinical and progress notes, summaries, and other documentation for the clinical record ... "</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases). Based on record review and interview,</p>			N 0602	<p>Supervising Registered Nurse has inserviced therapists on completing discharge assessments for patients upon discharge. 100% of patient charts were audited on 10/12/2015 and will be audited quarterly to ensure that discharge assessments have been completed for all patients discharged from therapy services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p> <p>N 602 The Supervising Registered</p>		10/12/2015

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	<p>the agency failed to ensure that the Registered Nurse updated the home health aide written care instructions in relation to patients ongoing refusal of the home health duties to be performed for 1 of 7 records reviewed with home health aide services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, SOC (start of care) 09/29/14, included a plan of care established by the physician for certification period 07/26/15 to 09/23/15, with orders for home health aide services to provide bathing and hygiene 7 days a week for 8 weeks then 4 days a week for one week.</p> <p>a. Review of the home health visit notes between 07/26/15 to 09/07/15, the home health aide failed to provide bathing and hygiene on all visits between during this time period.</p> <p>b. Review of the supervisory visit notes dated 08/05, 08/19, and 09/02/15. The supervisory notes indicated the home health aide was following the assigned duties and there were no changes to the home health aide care plan. The supervisory note dated 09/02/15 indicated the home health aide was present. The Registered Nurse failed to review and</p>		<p>Nurse has inserviced Registered Nurses on following the plan of care established by the physician, notifying the physician of any changes in patient status, reviewing and updating care plans on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicating assessment results to the physician and making relevant changes.</p> <p>100% of patient charts were audited on 10/12/2015 and will be audited quarterly for four quarters to ensure that the Registered Nurses notified the physician of any changes in patient status, reviewed and updated care plans and aide worksheets on an ongoing basis, within 5 days of identifying change but no less than every 60 days, communicated assessment results to the physician, made relevant changes and followed the plan of care established by the physician.</p> <p>The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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N 0608 Bldg. 00	<p>update the home health aide written care instructions.</p> <p>2. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>3. An undated policy titled Home Health Aide Services indicated, " The Agency shall provide home health aide services by appropriately qualified home health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist ... Home Health aide services shall include but not be limited to: Assisting the client to maintain personal hygiene. Assisting the client with ambulation as appropriate. Planning and preparing meals. Maintaining a health, safety environment "</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (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.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>1A. Based on record review and interview, the agency failed to ensure initial assessments were completed within 48 hours in relation to the agency's inability to provide information to verify that the time requirement was met for 9 of 9 records reviewed.</p> <p>Findings include:</p> <p>1A. Patient record #1, SOC (start of care) 11/27/13. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>2A. Patient record #2, SOC 12/15/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>3A. Patient record #3, SOC 06/24/15. The clinical failed to ensure initial</p>	N 0608	<p>N 608</p> <p>The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that documentation is written and maintained to verify that the time requirement for completing initial assessment (24-48 hours of referral or discharge from a facility unless otherwise ordered by a physician.) is met by the use of the referral log which will be easily accessible. The Supervising Registered Nurse has updated the referral log and will audit the referral log monthly and quarterly to ensure that the referral log is well documented with all the referrals, it is maintained by qualified staff and is easily accessible to be used to ascertain that the time requirement has been met for initial assessments. 100% of initial assessment dates will be audited against the referral data in the referral log to ensure that the time requirement for completing assessments was met. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will</p>	10/09/2015	

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	<p>assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>4A. Patient record #4, SOC 09/24/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>5A. Patient record #5, SOC 09/25/12. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>6A. Patient record #6, SOC 02/13/14. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>7A. Patient record #7, SOC 01/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>8A. Patient record #8, SOC 07/30/15.</p>		<p>not recur.</p> <p>The Administrator has in servicedhealthcare professionals on maintaining the clinical record in such a mannerthat it is current, assembled and filed in a timely manner in accordance withlaw and regulation. 100% of patient charts were audited by 10/06/2015 and willbe audited quarterly thereafter to ensure that all is assembled and filed in atimely manner and in accordance with law and regulation.</p> <p>The Administrator is responsible for monitoring these corrective actionsto ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>9A. Patient record #9, SOC 04/13/15. The clinical failed to ensure initial assessments were completed within 48 hours due to the agency's inability to provide information to verify that the time requirement was met.</p> <p>10A. The Administrator was interviewed on 09/18/15 at 4:30 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above.</p> <p>11A. An undated policy titled Referral and Acceptance of Clients indicated, "The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. Only qualified staff may take referral information. A log of all persons referred for service will be maintained ... Clients will be evaluated by a nurse or appropriate staff member within 24 - 48 hours of referral or discharge from a facility unless otherwise ordered by the physician ... "</p>			

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	<p>B. Based on record review and interview, the agency failed to ensure clinical records were complete and current in relation to missing visit notes for * of 9 records reviewed.</p> <p>Findings include:</p> <p>1B. Clinical record #2, SOC 12/15/14, failed to evidence home health aide visit notes after 09/09/15 and skilled nursing visit notes after 09/11/15.</p> <p>2B. Clinical record #3, SOC 06/24/15, failed to evidence home health aide visit notes after 09/11/5, physical therapy notes after 09/02/15 and occupational therapy notes after 09/04/15.</p> <p>3B. Clinical record #4, SOC 09/29/14, failed to evidence home health aide visit notes 09/07/15.</p> <p>4B. Clinical record #5, SOC 09/25/14, failed to evidence home health aide visit notes after 09/05/15.</p> <p>5B. Clinical record #6, SOC 02/13/14, failed to evidence home health aide visit notes after 09/08/15.</p> <p>6B. Clinical record #7, SOC 01/13/15, failed to evidence home health aide visit notes after 09/03/15.</p>			

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	<p>7B. Clinical record #8, SOC 07/30/15, failed to evidence attendant care visit notes after 08/17/15.</p> <p>8B. Clinical record #9, SOC 04/03/15, failed to evidence skilled nursing visit notes after 09/09/15.</p> <p>9B. During the entrance conference on 09/15/15 at 11:30 AM, the Administrator stated that the time frame allowed for clinicians to turn in documentation following a visit is 48 hours and 7 days for documents to be filed in the patient records.</p> <p>10B. After the entrance conference on 09/15/15 at 12:00 PM, the Administrator was instructed to provide all patient records at once for review. At 12:20 PM, only one record had been provided. The Administrator was observed taking a record to the front reception desk area. At 1:15 PM, the Administrator was interviewed on reason for delay of clinical records. The Administrator stated that she was making sure the charts were complete due to her office manager had quit the previous week and she was behind on filing. On 09/18/15 at 2:00 PM, the Administrator was given the opportunity to provide any missing documentation to the surveyor that was</p>			

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	not in the patients record. 11B. An undated policy titled Clinical Record Contents and Maintenance indicated, "The Agency will maintain a clinical record for all clients ... The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation ... Clinical progress notes [clinical notes are written the day of the service delivery and incorporated into the record at least weekly ... "				