

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
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NAME OF PROVIDER OR SUPPLIER ALL AGES HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032
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G 000 Bldg. 00	<p>This was a home health agency federal initial medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: 4-20, 4-21, 4-22, and 5-4-2015</p> <p>Facility Number: IN013568</p> <p>Since Provisional License: Skilled: 10 Home Health Aide Only: 4 Personal Service Only: 6 Total: 20</p> <p>Current Census Service Type: Skilled: 10 Home Health Aide Only: 1 Personal Service Only: 5 Total: 16</p> <p>Sample: Record Review with Home Visit: 4 Record Review without Home Visit: 7 Total: 10 (reviewed one record for skilled nursing and home health aide)</p> <p>QA: JE 5/11/15</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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G 104 Bldg. 00	<p>484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.</p> <p>Based on observation, agency patient admission packet review, clinical record review, and interview, the agency failed to ensure patients were advised, orally and in writing, in advance of furnishing care, of their right to respect of person and right to have patient's representative exercise the patient's rights when the patient has been judged incompetent for 10 of 10 records reviewed (1 - 10).</p> <p>Findings include:</p> <p>1. During home observation on 4-21-15 at 8:30 AM, patient (CR) 2, start of care (SOC) 3-3-15, it was noted the patient's admission packet contained agency document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged</p>	G 104	The Patient Bill of Rights for All Ages Home Health Care, Inc. has been revised. Both the State of Indiana Regulations and the Federal Guidelines for Patient Rights were incorporated verbatim, thereby guaranteeing the patient and/or their family will be notified orally and in writing of the right to have a patient's representative exercise the patient's rights when a patient has been judged incompetent. All currently active patients have received a copy of the new Patient Bill of Rights and signed a receipt along with an explanation of the document. A copy has been placed in the home file and office chart of all active patients. All subsequent patient admissions will contain the new Patient Bill of Rights to prevent recurrence of this deficiency.	05/11/2015

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	<p>incompetent. The agency CR evidenced the same document.</p> <p>2. Patient admission packet reviewed on 4-20-15 evidenced a document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>3. CR 1, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>4. CR 3, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>5. CR 4, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p>			

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	<p>6. CR 5, SOC, 1-19-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>7. CR 6, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>8. CR 7, SOC, 4-1-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>9. CR 8, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>10. CR 9, SOC, 1-15-15, evidenced a</p>			

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	<p>document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>11. CR 10, SOC, 1-16-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>12. On 4-20-15 at 11:00 AM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated all the agency packets prepared and provided to patients failed to notify the patient of the right to have patient's representative excesses patient's rights when the patient has been judged incompetent. She indicated agency staff use the Bill of Rights document as a guide to orally explain to patients their rights, and the patient's right to have patient's representative excesses patient's rights when the patient has been judged incompetent had probably not been explained orally to any of the agency patients.</p>			

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G 106 Bldg. 00	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on observation, agency patient admission packet review, clinical record review, and interview, the agency failed to ensure patients were advised, orally and in writing, in advance of furnishing care, of their right to voice grievances about care that fails to be furnished for 10 of 10 clinical records reviewed (1 - 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home observation on 4-21-15 at 8:30 AM, the admission packet of patient (CR) 2, start of care (SOC) 3-3-15, included a document titled "All Ages Home Health Care Inc. Patient Bill of Rights." The document failed to evidence the patient was notified of the right to voice grievances about care that fails to be furnished. 2. Patient admission packet reviewed on 			G 106	<p>The Patient Bill of Rights for All Ages Home Health Care, Inc. has been revised. Both the State of Indiana Regulations and the Federal Guidelines for Patient Rights were incorporated verbatim, thereby guaranteeing the patient and/or their family will be notified orally and in writing of the right to voice a grievance about care that fails to be furnished. All currently active patients have received a copy of the new Patient Bill of Rights and signed a receipt along with an explanation of the document. A copy has been placed in the home file and office chart of all active patients. All subsequent patient admissions will contain the new Patient Bill of Rights to prevent a recurrence of this deficiency.</p>		05/11/2015

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	<p>4-20-15 evidenced a document "All Ages Home Health Care Inc. Patient Bill of Rights", failed to notify patient of her right to voice grievances about care that fails to be furnished. The agency clinical record evidenced the same document.</p> <p>3. CR 1, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>4. CR 3, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>5. CR 4, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>6. CR 5, SOC, 1-19-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p>						

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	<p>7. CR 6, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>8. CR 7, SOC, 4-1-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>9. CR 8, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>10. CR 9, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>11. CR 10, SOC, 1-16-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be</p>			

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G 108 Bldg. 00	<p>furnished.</p> <p>12. On 4-20-15 at 11:00 AM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated all the agency packets prepared and provided to patients failed to notify patients of their right to voice grievances about care that fails to be furnished. She indicated agency staff use the Bill of Rights document as a guide to orally explain to patients their rights, and the right to voice grievances about care that failed to be furnished had probably not been explained orally to any of the agency patients.</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be</p>			
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	<p>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 agency document review, clinical record review, and interview, the agency failed to ensure all patients were advised, prior to services being furnished, of the frequency of visits for proposed services for 1 of 10 clinical records reviewed (8).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency document "All Ages Home Health Care, Inc. Patient Bill of Rights", last reviewed/revised 6-9-14, states "You have the right to know ... the frequency of visits proposed to be furnished." 2. Clinical record 8, start of care 1-15-15, contained an agency agreement/consent form that failed to evidence the patient had been advised of proposed frequency of visits for physical therapy and homemaker personal services. 3. During interview on 5-4-15 at 4:00 PM, the administrator, Employee A, indicated the agency should have informed the patient of the proposed frequency of visits at the start of care. 	G 108	<p>All active patient charts were reviewed by the Director of Nursing to be sure all patients had been provided frequency of visits and disciplines to be provided. The one patient who had not been informed was given oral and written verification of the disciplines being provided and the frequency of the visits. The administrator, Direct of Nursing and Staff Registered Nurses participated in an in-service of the requirements to provide orally and in-writing the disciplines to be provided and the frequency of visits planned at the time of admission. The Director of Nursing will be responsible for monitoring this as an ongoing responsibility to prevent this deficiency from recurring.</p>	05/11/2015

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G 134 Bldg. 00	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p> <p>Based on personnel file review and interview, the administrator failed to ensure employees had received orientation to agency policies, procedures, and their specific job duties for 6 of 7 employees whose personnel files were reviewed. (B, D, E, G, H, I)</p> <p>Finding included:</p> <p>1. Employee B, alternate administrator and nursing supervisor, date of hire (DOH) 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of nursing supervisor and alternate administrator.</p> <p>2. Employee D, alternate nursing supervisor and staff nurse, DOH 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of alternate nursing supervisor and staff nurse.</p>			G 134	<p>The Administrator will be responsible to review each personnel file and verify that each employee receives the appropriate orientation for their discipline at the time of hire. Employees B, D, E, G, H & I had received orientation but the Administrator failed to document the orientation in writing. Each employee's orientation was reviewed and documented in writing and placed in the appropriate personnel file. The Director of Nursing and Administrator will coordinate a review of each employee hiring procedure to document orientations specific to the job they fill to prevent recurrence of this deficiency.</p>		05/29/2015

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	<p>3. Employee E, staff registered nurse (RN), DOH 2-23-15, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the position of staff RN.</p> <p>4. Employee G, occupational therapist, DOH 6-24-14, date of 1st patient contact 1-5-15, personnel file failed to evidence the agency had provided orientation to the position of occupational therapist.</p> <p>5. Employee H, physical therapist, DOH 2-2-14, date of 1st patient contact 11-14-14, personnel file failed to evidence the agency had provided orientation to the position of physical therapist.</p> <p>7. Employee I, home health aide and personal service homemaker, DOH 1-14-15, date of 1st patient contact 1-15-15, personnel file failed to evidence the agency had provided orientation to the positions of home health aide and personal service homemaker.</p> <p>8. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated Employees B, D, E, G, H, and I had not been provided orientation to agency policies, procedures, and their specific job duties.</p>			

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G 158 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure visits were furnished as ordered on the plan of care in 2 of 3 active patient records reviewed (1, 2).</p> <p>Findings include:</p> <p>1. Agency policy "Plan of Care", last reviewed/reviewed 6-9-14, states " Home Care services are furnished under the supervision and direction of the client's physician."</p>	G 158	<p>The Director of Nursing will be responsible for monitoring the visit scheduled for each patient in accordance with the physician's orders and Plan of Care. All missed visits will be documented and the physician notified. A notation was placed in the chart noting the missed visit by the Physical Therapist as a late entry. A notation of the missed visit by the Home Health Aide of 03/17/2015, 03/31/2015 and 04/07/2015 were documented as a late entry. The Director of Nursing will prevent the recurrence of this deficiency through weekly monitoring of patient's Plan of Care visits ordered and</p>	05/20/2015

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	<p>2. Clinical record (CR) 1, start of care 11-14-14, contained a physician's plan of care for certification period 3-14-15 to 5-13-15 with orders for skilled nursing and physical therapy services. Physical therapy (PT) was to visit 1 time each week for 9 weeks. The week of 4-5 to 4-11-15, the clinical record failed to evidence a PT visit was made. The missed visit form in the clinical record dated 4-1-15 evidenced the patient had other appointments and requested PT not come that day. The visit was not rescheduled and the clinical record failed to evidence the physician had been notified of this deviation from the visit frequency ordered on the plan of care.</p> <p>3. CR 2, start of care 3-3-15, contained a physician's plan of care for certification period 3-3-15 to 5-3-15 with orders for home health aide services 2 times a week for 9 weeks. The record failed to evidence home health aide services were conducted on 3-17-15, 3-31-15, and 4-7-15 and the record failed to evidence documentation of the patient's notification prior to the missed visits or that the physician had been notified of the deviation from visit frequency ordered on the plan of care.</p> <p>4. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated 3</p>		<p>verification of these visits or documentation of missed visits and notification of the patient's physician.</p>	

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NAME OF PROVIDER OR SUPPLIER ALL AGES HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032
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G 159	484.18(a) PLAN OF CARE home health aide visits had been missed during the certification period for patient in CR 2. She indicated the clinical record failed to evidence the patient had been contacted prior to the missed visit to ensure patient's needs would be met, and failed to evidence the attending physician had been notified home health aide visits had not been furnished according to plan of care orders. For CR 1, the missed visit form failed to document the physician had been notified of the missed visit the week of 4-5 to 4-11-15. She indicated the attending physicians had not been notified in either case.			

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Bldg. 00	<p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on policy review, observation, clinical record review, and interview, the agency failed to ensure all durable medical equipment in the home was included on the plan of care for 4 of 8 active clinical records reviewed (1, 2, 3, 8), failed to ensure the plan of care identified the patient's nutritional requirements for 2 of 3 active records reviewed (1, 7), failed to ensure the certification period was correctly identified for 1 of 10 clinical records reviewed (8), failed to ensure an order for oxygen was on the plan of care for 1 of 1 clinical records reviewed of patients using oxygen therapy (8), and failed to ensure specific wound care orders were included on the plan of care prior to furnishing wound care for 1 of 1 clinical records reviewed of patients receiving wound care (2).</p>	G 159	<p>Items #1, 2, 3, 4 The Director of Nursing in-serviced the staff on therequirement to document all durable medical equipment and assistive devices onpatient admission and the office to be advised of any additions by the staff inthe home.</p> <p>Items #1, 2, 5 Staff was also in-serviced on the vital need to document nutritionalrequirements on the Plan of Care. Sitedwas the example of a staff member "filling in" for the patient's regular caregiverand being unaware of specific dietary needs if not documented.</p> <p>Items #1, 6 The staff was in-serviced on the fact that oxygen isconsidered a medication and must be documented as a type of vehicle to provideoxygen (method of delivery), if by mask or nasal cannula, liters per minute,usage per day, oxygen safety and all these facets documented by a doctor'sorder and on the Plan of Care. Theprofessional staff was in-serviced on the</p>	05/11/2015			

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Plan of Care", last reviewed/reviewed 6-9-14, states, "The Plan of Care shall be completed in full to include: specific dietary or nutritional requirements or restrictions ... medical supplies and equipment needed ... medications, treatments, and procedures ... other appropriate items." 2. During home observation on 4-20-15 at 4:45 PM to patient #1, start of care (SOC) 11-14-14, a cane was observed in the home which the patient used during the observation. The clinical record (CR) contained a plan of care (POC) for the certification period 3-14-15 to 5-14-15 that failed to evidence patient's cane as durable medical equipment and failed to evidence the patient's nutritional requirements. 3. During home observation on 4-21-15 at 8:30 AM to patient # 2, SOC 3-3-15, a cane was observed in the home which the patient stated she uses occasionally to ambulate. CR 2 contained a POC for the 		<p>requirement to document with aphysician's order for the specific wound care ordered and any changes in woundcare per physicians order.</p> <p>The Director of Nursing will be responsible for reviewingpatient care plans and physician's orders on a weekly basis and securingPhysician's Order for care changes as needed on each patient to preventrecurrence of this deficiency.</p>	

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	<p>certification period 3-3-15 to 5-3-15, with orders for SN and home health aide services that failed to evidence patient's cane as durable medical equipment. The registered nurse, Employee E, was observed to furnish wound care to gluteal fold area including, cleansing the area with chlorhexadine, drying, measuring wound, applying calcium alginate 4 x 4 inch dressing, and securing with tape. CR 2 evidenced a physician's order for "skilled nursing visits 1-3 times a week to treat pressure sore-decubitus on area of gluteal fold coccyx." The plan of care failed to evidence specific orders for wound care. Employee E performed wound care on 3-13, 3-17, 3-10, 3-24, 3-27, 3-31, 4-3, 4-8, 4-10, 4-15, 4-17, and 4-21-2015.</p> <p>4. During home observation on 4-21-15 at 5:15 PM to Patient 3, a shower/bath chair was observed in the bathroom. The patient's spouse indicated the patient used this to shower/bathe. The POC for the certification period 4-4 to 6-3-15 failed to evidence the bath/shower chair as durable medical equipment.</p> <p>5. CR 7, SOC 4-1-15, contained a POC for the certification period 4-1 to 6-3-15</p>			

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	<p>that failed to evidence the patient's nutritional requirements.</p> <p>6. CR 8, SOC 1-15-15. contained a POC for the certification period 4-9- (resumption of care date) to 6-8-15. The patient had a single episode of care which evidenced a transfer of care on 3-12-15 and resumption of care on 4-9-15. The POC evidenced an oxygen concentrator as durable medical equipment (DME). The POC failed to evidence a tub/shower chair as DME. The occupational therapy (OT) visit note from 4-11-15 evidenced tub/shower chair as DME. OT note dated 1-15-15 evidenced patient uses oxygen at 2 liters per minute, per nasal cannula, via an oxygen concentrator as needed for dyspnea. The POC failed to evidence tub/shower chair as durable medical equipment and failed to evidence a physician's order for oxygen, indications for use (continuous or as needed), the setting of liters per minute, and the method of delivery.</p> <p>7. On 4-22-15 at 2:15 PM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated CR 1, 2, 3, and 8 should have included all the durable medical equipment in the patients' homes, and CR 1 and 7 should have included patient's nutritional requirements. Employee B indicated she had failed to obtain a wound care order clarification to include</p>			

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G 175 Bldg. 00	<p>specific order for cleansing and dressing materials for Patient 2. The administrator indicated CR 8 had incorrect dates for the patient's first re-certification period, which should have been 3-16-15 to 5-14-15; failed to list all the DME in the home; and failed to include a physician's order for oxygen therapy. Employee B, nursing supervisor, indicated she had erroneously changed the certification period for CR 8 to coincide with the resumption of care date.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on policy review, observation, clinical record review, and interview, the agency failed to ensure the registered nurse implemented preventative and evaluative nursing measures for 3 of 3 active records reviewed (1, 2, 3).</p> <p>Findings include:</p> <p>1. Agency policy "Skilled Nursing Services", reviewed/reviewed 6-9-14, states "The registered nurse: ... Provides services requiring specialized nursing skill and initiates appropriate</p>	G 175	The Staff was in-serviced on the need for the implementation of safety measures on all patients on admission and updated as needed with patient care changes and needs changes per direction of the Director of Nursing the staff will now complete a Tinetti Evaluation, Braden Scale, Pain Evaluation and any other safety measure updates with each recertification and re-evaluation in addition to being completed on an as needed basis. The Director of Nursing is responsible for ongoing monitoring of patient care and safety measures evaluation to prevent recurrence of the deficiency.	05/11/2015			

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	<p>preventative and rehabilitative nursing procedures."</p> <p>2. On 4-20-15 12/12/14 at 4:45 PM, a home visit was made to patient 1. The patient was observed to have an abnormal gait. Clinical record (CR)1, start of care (SOC) 11-14-14, contained a plan of care (POC) for the certification period 3-14 to 5-13-15, with orders for skilled nursing (SN) 1 time per week to include set up medications, monitor vital signs and physical therapy (PT) to include upper and lower body strengthening. The area of the POC "safety measures" was blank.</p> <p>3. On 4-21-15 at 8:30 AM, a home observation was made to patient 2. The patient used a walker or a cane to ambulate. The patient indicated in conversation with RN, Employee E, she had fallen in her kitchen and broken her hip shortly before coming on service with the agency. The POC for the certification period of 3-3 to 5-3-15 failed to evidence safety measures.</p> <p>4. During home observation on 4-21-15 at 5:15 PM to patient 3, a shower/bath chair was observed in the bathroom of the home. The spouse of patient 3 indicated patient 3 used this to shower/bathe because he was weak and unsteady on his feet. The POC for the</p>			

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G 187 Bldg. 00	<p>certification period 4-4 to 6-3-15 failed to evidence any "safety measures."</p> <p>5. On 4-22-15 at 2:15 PM, Employee A, administrator, and Employee B, nursing supervisor, indicated the RN should have implemented fall precautions as safety measures for patients 1 -3.</p> <p>484.32 THERAPY SERVICES The qualified therapist prepares clinical and progress notes.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the occupational therapist's</p>	G 187	The Therapy Staff was in-serviced on the need to do objective measurements and comparison of measurements. All measurements need to be specific and show progress	05/11/2015

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	<p>(Employee G) evaluation included objective measurement of function for 2 of 6 patients receiving therapy services (3, 8).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy "Therapy Services" , last reviewed/revised 6-9-14, states "Measurable treatment goals will be described in the the plan of care and the patient's clinical record would determine that the method used to assess a patient's function would include objective measurement and successful comparison of measurements, thus enabling objective measurement or progress towards goals and/or therapy effectiveness." Clinical record (CR) 3, start of care 2-3-15, contained a plan of care for the certification period 4-4 to 6-3-15, with orders for occupational therapy (OT) 1-2 times per week for 9 weeks for cognitive training, upper body strengthening exercises, balance training, and educate wife to assist husband safely. Start of care OT evaluation dated 2-9-15 failed to include muscle strength against gravity 		toward goals or regression if patient condition is deteriorating. The Director of Nursing will be responsible for reviewing Therapy notes on a weekly basis to advise therapist if items are lacking to prevent recurrence of this deficiency.				

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	<p>measurements and range of motion measurements.</p> <p>3. CR 8, SOC 1-15-15, contained a POC for the certification period 4-9 to 6-8-15 with order for OT 1-2 times per week for 9 weeks for upper body strengthening, teach body mechanics to reduce pain and SOB (sic shortness of breath), and improve ability to perform ADLs (sic activities of daily living). Evaluation by OT dated 1-15-15 failed to evidence range of motion and mobility measurements. Evaluation by OT dated 4-11-15 failed to evidence range of motion and mobility measurements.</p> <p>4. On 4-22-15 at 2:15 PM and 5-4-15 at 4:00 PM, Employee A, administrator, and Employee B, nursing supervisor, indicated the OT therapy evaluation note at SOC for patient 3 did not include objective functional measurements to provide a basis of determining progress towards goals and/or therapy effectiveness, as required by agency policy. For CR 8, the OT evaluations dated 1-15-15 and 4-11-15 did not include objective functional measurements to provide a basis of determining progress towards goals</p>			

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G 224 Bldg. 00	<p>and/or therapy effectiveness, as required by agency policy.</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on observation, clinical record review, and interview, the agency failed to ensure the home health aide (HHA) care plan included the frequency for HHA duties for 1 of 1 active patients receiving HHA (2) services the HHA care plan included the patient's nutritional requirements for 1 of 1 active records</p>	G 224	The professional staff was in-serviced on the correct completion of the Home Health Aide Care Plan to include frequency of duties assigned. Included in the in-servicing was the need to do a Change of Care documentation as required by the patient status and make the appropriate changes in the Home Health Aide Plan of Care and	05/11/2015

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G 337 Bldg. 00	<p>reviewed of patients receiving HHA services (2).</p> <p>Findings include:</p> <p>1. HHA care plan for patient #2, dated 2-26-15, evidenced HHA duties of bed bath, shampoo, walking, transfer, reposition, and dressing upper and lower. The written HHA instructions failed to evidence a frequency for the duties of bed bath, shampoo, hair care, and skin care.</p> <p>3. On 4-22-15 at 2:15 PM, the administrator, Employee A, and the nursing supervisor, Employee B, indicated the HHA care plan for patient 2 did not include the frequency of duties.</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.</p> <p>Based on observation, policy review, clinical record review, and interview, the agency failed to ensure the medication profile included all the medications the patient was taking for 1 of 3 home visits</p>			G 337	<p>educate the Home Health Aide of any changes. The Director of Nursing is responsible for monitoring patient care and conferencing with other professional staff to determine specific patient needs and instituting the appropriate changes and securing physicians orders to such as needed. By doing this, the Director of Nursing will prevent recurrence of this deficiency.</p> <p>The professional staff was in-serviced on the requirement of detailed documentation and correctness of this documentation. Also, the need to cross reference chart information to verify complete and correct documentation. The medication record on the patient</p>		05/11/2015

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	<p>whose clinical records (CR) were reviewed (1).</p> <p>Findings include:</p> <p>1. On 4-20-15 at 5:00 PM, during home visit of Patient 1 to observe physical therapy services, the patient indicated patient had been hospitalized recently for chest pain and had nitroglycerine sublingual tablets in the home to be taken as needed as directed by physician.</p> <p>2. Agency policy, "Plan of Care", last reviewed/revised 6-9-14, states "Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every 60 days ... The Plan of Care shall be completed in full to include: ... Medications, treatments, and procedures ... "</p> <p>3. CR 1, start of care 11-14-14, contained a physician's plan of care for certification period 3-14-15 to 5-13-15. The POC evidenced Nitrostat 0.4 mg sublingual as needed for chest pain. The medication profile updated 4-13-15 failed to evidence the Nitrostat as a prescribed medication.</p>		<p>inquestion was corrected by the patients nurse.</p> <p>The Director of Nursing will be responsible for reviewing all Patient Admissions, Resumption of Care, Re-evaluations and 60 Day Certificationsto prevent a recurrence of this deficiency.</p>				

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G 339 Bldg. 00	<p>4. On 4-22-15 at 2:15 PM, the administrator, Employee A, and nursing supervisor, Employee B, indicated the medication profile did not include all Patient 1's medications.</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on policy review, clinical record</p>	G 339	The professional staff was in-serviced on the need for a comprehensive and detailed	05/11/2015
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	<p>review, and interview, the agency failed to ensure the comprehensive assessment was updated to include re-assessment of risk for pressure ulcer at re-certification for 1 of 4 clinical records reviewed of patients receiving care 60 days or more (3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy "Comprehensive Client Assessment" , last reviewed/revised 6-9-14, states, "In addition to general health status/system assessment, the agency comprehensive assessment tool with OASIS will include: Integumentary status, Pressure ulcer risk assessment ... Reassessments are conducted based on ... regulatory requirement ... " Clinical record 3, start of care 2-3-15, contained a follow-up (re-certification) comprehensive assessment dated 4-3-15 that failed to evidence an assessment of pressure ulcer risk. On 4-22-15 at 2:15 PM, the administrator, Employee A, and nursing supervisor, Employee B, indicated the agency uses the Braden assessment tool to determine risk of pressure ulcer. Clinical Record 3 follow-up assessment dated 4-3-15 did not include a pressure 		<p>assessment of each patient on Admission, Resumption of Care, Re-Evaluation and 60 Day Recertification. To facilitate this assessment, the agency has purchased and instituted the entire Briggs OASIS forms series. Also, on each of the above patient situations, the staff will complete a Falls Risk, Tinetti, Braden Scale, Pain Evaluation and records of any safety measures as needed and taught. The Director of Nursing will be responsible for monitoring patient documentations as completed by the staff to note the inclusion of these items or to advise the staff to re-assess if any are absent as this documentation is submitted thereby preventing a recurrence of the deficiency.</p>				

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G 342 Bldg. 00	<p>ulcer risk re-assessment which should have done by the registered nurse as required by agency policy.</p> <p>484.55(e) INCORPORATION OF OASIS DATA ITEMS The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.</p> <p>Based on interview and clinical record review, the agency failed to ensure the agency the comprehensive assessment incorporated the OASIS items for 4 of 5 clinical records reviewed (1, 2, 3, 4).</p>	G 342	The professional staff was in-serviced on the need to integrate the OASIS items into the agency assessments. To rectify the problem the entire Briggs OASIS forms set was purchased and put into practice immediately. The professional staff will complete aTinetti,	05/11/2015

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	<p>Findings include:</p> <p>1. On 4-22-15 at 2:15 PM, administrator, Employee A, and nursing supervisor, Employee B, indicated the agency was using an OASIS C-1, ICD 9 form downloaded from the Centers for Medicare and Medicaid Services website for OASIS / comprehensive assessments. The OASIS C-1, ICD 9 form included only OASIS data set items. At time of assessment, the registered nurse attaches a narrative form to the OASIS with additional assessments such as nutritional status and durable medical equipment. The administrator indicated the assessments in clinical records 1-5, and all clinical records since first patient admitted on 11-14-14, contained OASIS forms at start of care, transfer, resumption of care, and discharge which failed to integrate the OASIS items into agency assessments.</p> <p>2. Clinical record (CR) 1, start of care (SOC) 11-14-14, contained a recertification assessment dated 3-12-15 that failed to integrate the OASIS items</p>		<p>Braden Scale, Pain Evaluation and Safety measures on every patient Admission, Re-Evaluation, Resumption of Care and 60 Day Recertification. The Director of Nursing is responsible for monitoring this documentation on an ongoing basis as it is submitted by the staff and securing any documentation that might be accidently omitted to prevent a recurrence of this deficiency.</p>				

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	<p>into the agency's assessment.</p> <p>3. CR 2, SOC 3-3-15, contained a SOC comprehensive assessment dated 3-3-15 that failed to integrate the OASIS items into the agency's assessment.</p> <p>4. CR 3, SOC 2-3-15, contained a follow-up (re-certification) comprehensive assessment dated 4-3-15 that failed to integrate the OASIS items into the agency's assessment.</p> <p>5. CR 4, SOC 2-3-15, contained a start of care comprehensive assessment dated 2-3-15 that failed to integrate the OASIS items into the agency's assessment.</p> <p>6. On 4-22-15 at 2:15 PM, the administrator, Employee A, and nursing supervisor, Employee B, indicated CR 1 -4 and all agency clinical records that were not Personal Services Homemaker or Companion only services, contained comprehensive assessments that failed to integrate the OASIS items into the agency's assessment. She indicated the agency was in the process of obtaining a standard form from a vendor that met the</p>			

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N 000 Bldg. 00	<p>requirement to integrate the OASIS items into the agency's assessment.</p> <p>This was a home health agency initial state licensure survey.</p> <p>Survey Dates: 4-20, 4-21, 4-22, and 5/4/15</p> <p>Facility Number: IN013568</p> <p>Since Provisional License: Skilled: 10 Home Health Aide Only: 4 Personal Service Only: 6 Total: 20</p>	N 000		

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N 446 Bldg. 00	<p>Current Census Service Type: Skilled: 10 Home Health Aide Only: 1 Personal Service Only: 5 Total: 16</p> <p>Sample: Record Review with Home Visit: 4 Record Review without Home Visit: 2 Total: 5 (reviewed one record for skilled nursing and home health aide)</p> <p>QA: JE 5/1/15</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 personnel file review and interview, the administrator failed to ensure employees had received orientation to agency policies, procedures, and their specific job duties for 6 of 7 employees whose personnel files were reviewed. (B, D, E, G, H, I)</p>	N 446	The Administrator will be responsible to review each personnel file and verify that each employee receives the appropriate orientation for their discipline at the time of hire. Employees B, D, E, G, H & I had received orientation but the Administrator failed to document the orientation in writing. Each	05/29/2015

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	<p>Finding included:</p> <ol style="list-style-type: none"> Employee B, alternate administrator and nursing supervisor, date of hire (DOH) 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of nursing supervisor and alternate administrator. Employee D, alternate nursing supervisor and staff nurse, DOH 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of alternate nursing supervisor and staff nurse. Employee E, staff registered nurse (RN), DOH 2-23-15, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the position of staff RN. Employee G, occupational therapist, DOH 6-24-14, date of 1st patient contact 1-5-15, personnel file failed to evidence the agency had provided orientation to the position of occupational therapist. Employee H, physical therapist, DOH 2-2-14, date of 1st patient contact 11-14-14, personnel file failed to evidence the agency had provided 		<p>employee's orientation was reviewed and documented in writing and placed in the appropriate personnel file. The Director of Nursing and Administrator will coordinate a review of each employee hiring procedure to document orientations specific to the job they fill to prevent recurrence of this deficiency.</p>				

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N 456 Bldg. 00	<p>orientation to the position of physical therapist.</p> <p>7. Employee I, home health aide and personal service homemaker, DOH 1-14-15, date of 1st patient contact 1-15-15, personnel file failed to evidence the agency had provided orientation to the positions of home health aide and personal service homemaker.</p> <p>8. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated Employees B, D, E, G, H, and I had not been provided orientation to agency policies, procedures, and their specific job duties.</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on review of agency documents, interview, and review of policy, the administrator failed to ensure the agency</p>	N 456	The Administrator has instituted a Quality Assurance Program which will include Patient Satisfaction Survey results and Fall Prevention for 2015. Satisfaction	05/20/2015			

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	<p>had adopted and implemented a quality assessment / performance improvement (QAPI) model and ongoing quality assessment and improvement program to include objective data; designed to objectively evaluate the quality, appropriateness of patient care, and resolve identified problems, and improve patient care for one 1 of 1 agency.</p> <p>Findings include:</p> <p>1. Agency policy "Performance Improvement" last reviewed/reviewed 6-9-14 states, "The agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes. This plan will be based on the organization's mission and goals and designed to improve client outcomes ... the agency will adopt a performance improvement model to guide the process ... Data will be collected to allow the agency to monitor its performance. Data will be collected, measured, and analyzed. The goal is to decide the statistical control methods, agree on how data will be collected, and determine how it will be measured. The agency will assess for improved efficient processes. Data collection will be prioritized based on the organization's mission, care services provided, and populations served</p>				<p>Surveys will be sent quarterly and on patient discharge and information compiled to assess improvement in patient care. The Performance Improvement Plan will be evaluated at least annually and presented to the Governing Body. As part of the Quality Improvement Program, staff will complete a Tinetti, Braden Scale Pain evaluation and Safety Assessment in addition to the OASIS for each patient Admission, Resumption of Care, Re-Evaluation and 60 Day Recertification which will be reviewed by the Director of Nursing and the information shared with the Administrator. The Administrator also contacted HHQI (Home Health Quality Improvement) regarding help in establishing a more proficient QI program thereby preventing recurrence of this deficiency.</p>		

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	<p>... The Performance Improvement Plan is evaluated at least annually and is incorporated into the annual agency evaluation required by CMS."</p> <p>2. Review of 3 consumer satisfaction surveys identified the agency failed to analyze the consumer satisfaction surveys and clinical records for objective data to use in the agency QAPI program.</p> <p>3. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated the agency had not yet adopted a quality improvement model to guide the agency establishment of objective and systematic monitors to evaluate quality and appropriateness of care, improve patient care, and resolve identified problems. She indicated the agency had not identified any problems from clinical record review and had not analyzed the customer satisfaction surveys for objective data to use in the QAPI program.</p>			

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N 458 Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (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.</p> <p>Based on personnel file review and interview, the agency failed to ensure employee files contained documentation of orientation for 6 of 7 employees whose personnel files were reviewed. (B, D, E, G, H, I)</p> <p>Finding included:</p>			N 458	<p>The Administrator will be responsible to review each personnel file and verify that each employee receives the appropriate orientation for their discipline at the time of hire. Employees B, D, E, G, H & I had received orientation but the Administrator failed to document the orientation in writing. Each employee's orientation was reviewed and documented in writing and placed in the</p>		05/29/2015

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	<p>1. Employee B, alternate administrator and nursing supervisor, date of hire (DOH) 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of nursing supervisor and alternate administrator.</p> <p>2. Employee D, alternate nursing supervisor and staff nurse, DOH 8-2-14, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the positions of alternate nursing supervisor and staff nurse.</p> <p>3. Employee E, staff registered nurse (RN), DOH 2-23-15, date of 1st patient contact 11-13-14, personnel file failed to evidence the agency had provided orientation to the position of staff RN.</p> <p>4. Employee G, occupational therapist, DOH 6-24-14, date of 1st patient contact 1-5-15, personnel file failed to evidence the agency had provided orientation to the position of occupational therapist.</p> <p>5. Employee H, physical therapist, DOH 2-2-14, date of 1st patient contact 11-14-14, personnel file failed to evidence the agency had provided orientation to the position of physical therapist.</p>		appropriate personnel file. The Director of Nursing and Administrator will coordinate a review of each employee hiring procedure to document orientations specific to the job they fill to prevent recurrence of this deficiency.				

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N 460 Bldg. 00	<p>7. Employee I, home health aide and personal service homemaker, DOH 1-14-15, date of 1st patient contact 1-15-15, personnel file failed to evidence the agency had provided orientation to the positions of home health aide and personal service homemaker.</p> <p>8. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated Employees B, D, E, G, H, and I had not been provided orientation at hire and before first patient contact. She indicated these employees had experience in home health.</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</p>			

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N 464 Bldg. 00	<p>(9) to fifteen (15) months of active employment. Based on personnel file review and interview, the agency failed to ensure the nursing supervisor was oriented to the job of nursing supervisor upon hire for 1 of 1 nursing supervisors (Employee B).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file of Employee B, nursing supervisor, date of hire 6-2-14, failed to evidence orientation to the job of nursing supervisor. 2. On 4-22-15 at 2:15 PM, administrator, Employee A, indicated no orientation had been conducted for the nursing supervisor. <p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result</p>			N 460	<p>The Administrator will be responsible to review each personnel file and verify that each employee receives the appropriate orientation for their discipline at the time of hire. Employees B had received orientation but the Administrator failed to document the orientation in writing. Each employee's orientation was reviewed and documented in writing and placed in the appropriate personnel file. The Director of Nursing and Administrator will coordinate a review of each employee hiring procedure to document orientations specific to the job they fill to prevent recurrence of this deficiency.</p>		05/29/2015

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	<p>was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis;</p> <p>or</p> <p>(B) newly positive results to the tuberculin skin test;</p> <p>must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on review of Center for Disease Control (CDC) tuberculosis (TB) skin</p>	N 464	The Administrator has instituted a new form for Employee Physicals and Tuberculosis Skin Testing which incorporates brand of serum used, lot number, time	05/29/2015

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NAME OF PROVIDER OR SUPPLIER ALL AGES HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032
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	<p>testing guidelines, personnel file review, and interview, the agency failed to ensure a TB skin test was performed within 12 MOS of previous negative TB skin test for 1 of 1 employees with TB skin test last administered more than 12 months ago (B); failed to ensure all employee TB tests were read between 48 to 72 hours for 4 of 6 non-positive Tuberculin Skin Test responders' files reviewed (B, D, E, H); failed to ensure 2 step TB skin tests were administered when a valid negative TB skin test was not documented in the last 12 months for 2 of 2 files reviewed of employees without a valid negative TB skin test result within 12 months (B, D); accepted only TB skin test results that had been authenticated by the person administering and reading the test for 2 of 6 non-positive Tuberculin Skin Test responders' files reviewed (B, D); and failed to ensure a negative TB skin test within 12 months, or a 2 step TB skin test with negative results was obtained prior to date of 1st patient contact for 1 of 1 non-positive TB responders' home health aide files reviewed (I).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. CDC Guidelines for Control and Prevention of TB "Tuberculosis Skin Testing Fact Sheet", last reviewed/updated September 2012 , 		<p>administered, area of administration, discipline of person administering the test, date read, time read, results and discipline of person reading the test. Personnel file B, Alternate Administrator and Nursing Supervisor did not receive a TB Skin Test because she presented a negative chest X-Ray and completed the Agency TB Test/Health Questionnaire for 2015. Employee I, Home Health Aide, did not have a TB Skin Test because she tests positive having lived with her grandfather who was an active TB patient. She was treated with INH approximately (12) twelve years ago and presented a negative chest X-ray dated 04/11/2014 prior to being hired. All other employees are retested utilizing the new TB test form to conform to the required information. The Director of Nursing and Administrator will review test results on all current and new employees to verify the negative results to prevent this deficiency from recurring.</p>	

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	<p>states, "The skin test reaction should be read between 48 and 72 hours after administration ... A patient who does not return within 72 hours will need to be rescheduled for another skin test."</p> <p>2. Personnel file B, alternate administrator and nursing supervisor, date of hire (DOH) 8-2-14, date of 1st patient contact 11-13-14, personnel file evidenced a TB skin test form with date of administration of 1-31-14 and date read of 2-3-14. The form failed to evidence the name and credentials of the person administering the test and reading the result. The time of administration and reading was not documented. The file failed to evidence a TB skin test for 2015 (due in February).</p> <p>3. Employee D, alternate nursing supervisor, DOH 8-2-14, date of 1st patient contact 11-13-14, personnel file evidenced a TB skin test within 12 months of hire which failed to evidence the time of the administration on 12-23-13 and the time of the reading on 12-26-13. The file evidenced a TB skin test form with date of administration 7-15-14 and date of reading of 0 mm induration on 7-18-14; however, the form failed to evidence the time of administration, time of reading, site of injection, and name of person and</p>			

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	<p>credentials administering and reading the test.</p> <p>4. Employee E, staff registered nurse, DOH 2-23-15, date of 1st patient contact 2-26-15, personnel file evidenced a negative TB skin test result within 12 months of hire but failed to evidence the date and time of administration, the time of the reading of the result of 0 mm induration, and the name and credentials of the person administering and reading the test. A TB skin test form with dates of administration of 2-5-15 and 2-6-15 and notation of 0 mm induration, read 2-9-15 "within 48-72 hours." The form failed to evidence the time of administration, and the time of reading.</p> <p>5. Employee H, physical therapist, DOH 6-2-14, date of 1st patient contact 11-14-14, personnel file evidenced a TB skin test form with date of administration 6-17-14; and date of reading 6-20-14. However, the form failed to evidence the time of administration and the time of reading contact.</p> <p>6. Employee I, home health aide, DOH 6-2-14, date of 1st patient contact 1-15-15, personnel file failed to evidence a negative TB skin test with 12 months of 1st patient contact or a 2 step TB skin test with negative results upon hire and prior</p>			

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N 470 Bldg. 00	<p>to 1st patient contact.</p> <p>7. On 4-22-15 at 2:15 PM, the administrator, Employee A, and nursing supervisor, Employee B, indicated the agency should have reviewed the TB skin tests and ordered re-testing when the TB skin test results were incomplete, untimely, or failed to document the date and time of administration, date and time of and reading, to reliably determine the reading had been performed within 48 to 72 hours. The administrator indicted the agency follows CDC guidelines. No further documentation was provided prior to exit.</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 document review and interview, the agency failed to adopt and implement an agency wide infection control plan and policy and failed to adopt and implement a tuberculosis (TB)</p>	N 470	The Agency does have an Infection Control Policy and TB Prevention and Monitoring Policy for Employees upon hire and annually thereafter. I believe this was amisunderstanding by the Administrator regarding	05/29/2015

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N 472 Bldg. 00	<p>prevention and monitoring policy of employees for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 4-22-15 at 2:00 PM, a copy of the agency Infection Control Policy and TB prevention and monitoring policy for employees upon hire and annually was requested. On 4-22-15 at 2:00 PM, the administrator, Employee A, indicated the agency did not have a policy that addressed an overall Infection Control Plan and policy based on a professional standard and did not have a TB prevention and monitoring policy for employees upon hire and annually. <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p>			N 472	<p>requested information. The Policy is in the Operations Guidelines under B401, Infection Control Plan, B402 Infection Control Surveillance, B403 Infection Prevention/Control, B405 OSHA Infection Control/Exposure Control Plan, B406 Cleaning and Disinfecting in the home and B415 Infections Disease Reporting. My apology for this misunderstanding. Copies will be forwarded for your review if you would like to verify. We adopted the Briggs Operation Guidelines. This deficiency will not be repeated.</p> <p>The Administrator has instituted a Quality Assurance Program which</p>		05/20/2015

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	<p>Based on agency document review, interview, and policy review, the administrator failed to ensure the agency had adopted and implemented a quality assessment and performance improvement plan including objective measures for one 1 of 1 agency.</p> <p>Findings include:</p> <p>1. Agency policy "Performance Improvement" last reviewed/reviewed 6-9-14 states, "The agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes. This plan will be based on the organization's mission and goals and designed to improve client outcomes ... the agency will adopt a performance improvement model to guide the process ... Data will be collected to allow the agency to monitor its performance. Data will be collected, measured, and analyzed. The goal is to decide the statistical control methods, agree on how data will be collected, and determine how it will be measured. The agency will assess for improved efficient processes. Data collection will be prioritized based on the organization's mission, care services provided, and populations served ... The Performance Improvement Plan is evaluated at least annually and is</p>		<p>will include Patient Satisfaction Survey results and Fall Prevention for 2015. Satisfaction Surveys will be sent quarterly and on patient discharge and information compiled to assess improvement in patient care. The Performance Improvement Plan will be evaluated at least annually and presented to the Governing Body. As part of the Quality Improvement Program, staff will complete a Tinetti, Braden Scale Pain evaluation and Safety Assessment in addition to the OASIS for each patient Admission, Resumption of Care, Re-Evaluation and 60 Day Recertification which will be reviewed by the Director of Nursing and the information shared with the Administrator. The Administrator also contacted HHQI (Home Health Quality Improvement) regarding help in establishing a more proficient QI program thereby preventing a recurrence of this deficiency.</p>				

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N 488 Bldg. 00	<p>incorporated into the annual agency evaluation required by CMS."</p> <p>2. Review of 3 consumer satisfaction surveys identified the agency failed to analyze the consumer satisfaction surveys and clinical records for objective data to use in the agency QAPI program.</p> <p>3. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated the agency had not yet adopted a quality improvement model to guide the agency establishment of objective and systematic monitors to evaluate quality and appropriateness of care, improve patient care, and resolve identified problems. She indicated the agency had not identified any problems from clinical record review and had not analyzed the customer satisfaction surveys for objective data to use in the QAPI program.</p> <p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in</p>						

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	<p>the following circumstances:</p> <p>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.</p> <p>(2) The patient refuses the home health agency's services.</p> <p>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or</p> <p>(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on agency document review and interview, the agency failed to develop a policy and agency documents which clearly require the agency to provide at least 5 calendar days notice to the patient or patient's representative before services are stopped for 1 of 1 agency.</p> <p>The findings include:</p> <p>1. On 4-20-15 at 11:30 AM, the agency admission packet provided to each patient at the start of care was reviewed. An agency document "All Ages Home Health Care, Inc, Home Care Consents and Agreements", not dated, states "All Ages Home Health Care, Inc. may</p>	N 488	The All Ages Home Health Care, Inc. Consents and Agreements to be signed by each patient, guardian, P.O.A. or designated signee has been amended. The seventy-two (72) hours was an error which has been removed and replaced by one hundred twenty (120) hours (5 days). All current patients have received a corrected form with an explanation of the change and have signed a receipt of the changes. By changing this agreement and consent, we will prevent recurrence of this deficiency. The Administrator will review admissions on an ongoing basis to prevent a recurrence of this deficiency.	05/11/2015			

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	<p>terminate this agreement by providing at least seventy-two (72) hours or such minimum notice as required by applicable state law, except for emergency terminations by either party for any reason."</p> <p>2. On 4-20-15 at 11:30 AM, the administrator, Employee A, indicated the agency document "All Ages Home Health Care, Inc, Home Care Consents and Agreements", which is explained orally and provided in writing to patients at the start of care, is confusing and does not clearly notify patient/patient representative of their right to at least 5 calendar days notice before agency services are stopped. She indicated the agency does not have a policy requiring 5 calendar days of notice of discharge.</p>			

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N 496 Bldg. 00	<p>410 IAC 17-12-3(b) 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: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law.</p> <p>Based on observation, agency patient admission packet review, clinical record review, and interview, the agency failed to ensure patients were advised, orally and in writing, in advance of furnishing care, of their right to respect of person and right to have patient's representative exercise the patient's rights when the patient has been judged incompetent for 10 of 10 records reviewed (1 - 10).</p> <p>Findings include:</p> <p>1. During home observation on 4-21-15 at 8:30 AM, patient (CR) 2, start of care (SOC) 3-3-15, it was noted the patient's admission packet contained agency document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent. The agency CR evidenced the same document.</p>			N 496	<p>The Patient Bill of Rights for All Ages Home Health Care, Inc. has been revised. Both the State of Indiana Regulations and the Federal Guidelines for Patient Rights were incorporated verbatim, thereby guaranteeing the patient and/or their family will be notified orally and in writing of the right to have a patient's representative exercise the patient's rights when a patient has been judged incompetent. All currently active patients have received a copy of the new Patient Bill of Rights and signed a receipt along with an explanation of the document. A copy has been placed in the home file and office chart of all active patients. All subsequent patient admissions will contain the new Patient Bill of Rights to prevent recurrence of this deficiency.</p>		05/11/2015

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	<p>2. Patient admission packet reviewed on 4-20-15 evidenced a document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>3. CR 1, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>4. CR 3, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>5. CR 4, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>6. CR 5, SOC, 1-19-15, evidenced a document "All Ages Home Health Care,</p>			

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	<p>Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>7. CR 6, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>8. CR 7, SOC, 4-1-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>9. CR 8, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>10. CR 9, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have</p>			

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	<p>patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>11. CR 10, SOC, 1-16-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify the patient of the right to have patient's representative exercise patient's rights when the patient has been judged incompetent.</p> <p>12. On 4-20-15 at 11:00 AM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated all the agency packets prepared and provided to patients failed to notify the patient of the right to have patient's representative excesses patient's rights when the patient has been judged incompetent. She indicated agency staff use the Bill of Rights document as a guide to orally explain to patients their rights, and the patient's right to have patient's representative excesses patient's rights when the patient has been judged incompetent had probably not been explained orally to any of the agency patients.</p>			

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N 500 Bldg. 00	<p>410 IAC 17-12-3(b)(2)(B) 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: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on observation, agency patient admission packet review, clinical record review, and interview, the agency failed to ensure patients were advised, orally and in writing, in advance of furnishing care, of their right to voice grievances about care that fails to be furnished for 10 of 10 clinical records reviewed (1 - 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home observation on 4-21-15 at 8:30 AM, the admission packet of patient (CR) 2, start of care (SOC) 3-3-15, included a document titled "All Ages Home Health Care Inc. Patient Bill of Rights." The document failed to evidence the patient was notified of the right to voice grievances about care that fails to be furnished. 2. Patient admission packet reviewed on 			N 500	<p>The Patient Bill of Rights for All Ages Home Health Care, Inc. has been revised. Both the State of Indiana Regulations and the Federal Guidelines for Patient Rights were incorporated verbatim. Thereby guaranteeing the patient and/or their family will be notified orally and in writing of the right to voice a grievance about care that fails to be furnished. All currently active patients have received a copy of the new Patient Bill of Rights and signed a receipt along with an explanation of the document. A copy has been placed in the home file and office chart of all active patients. All subsequent patient admissions will contain the new Patient Bill of Rights to prevent a recurrence of this deficiency.</p>		05/11/2015

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	<p>4-20-15 evidenced a document "All Ages Home Health Care Inc. Patient Bill of Rights", failed to notify patient of her right to voice grievances about care that fails to be furnished. The agency clinical record evidenced the same document.</p> <p>3. CR 1, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>4. CR 3, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights", that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>5. CR 4, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>6. CR 5, SOC, 1-19-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p>			

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	<p>7. CR 6, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>8. CR 7, SOC, 4-1-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>9. CR 8, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>10. CR 9, SOC, 1-15-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be furnished.</p> <p>11. CR 10, SOC, 1-16-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of her right to voice grievances about care that fails to be</p>			

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N 504 Bldg. 00	<p>furnished.</p> <p>12. On 4-20-15 at 11:00 AM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated all the agency packets prepared and provided to patients failed to notify patients of their right to voice grievances about care that fails to be furnished. She indicated agency staff use the Bill of Rights document as a guide to orally explain to patients their rights, and the right to voice grievances about care that failed to be furnished had probably not been explained orally to any of the agency patients.</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.</p> <p>Based on agency document review, clinical record review, and interview, the agency failed to ensure all patients were</p>	N 504	All active patient charts were reviewed by the Director of Nursing to be sure all patients had been provided frequency of visits and disciplines to be provided. The one patient who	05/11/2015			

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N 512 Bldg. 00	<p>advised, prior to services being furnished, of the frequency of visits for proposed services for 1 of 10 clinical records reviewed (8).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency document "All Ages Home Health Care, Inc. Patient Bill of Rights", last reviewed/revised 6-9-14, states "You have the right to know ... the frequency of visits proposed to be furnished." Clinical record 8, start of care 1-15-15, contained an agency agreement/consent form that failed to evidence the patient had been advised of proposed frequency of visits for physical therapy and homemaker personal services. During interview on 5-4-15 at 4:00 PM, the administrator, Employee A, indicated the agency should have informed the patient of the proposed frequency of visits at the start of care. <p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse.</p>				<p>had not been informed was given oral and written verification of the disciplines being provided and the frequency of the visits. The administrator, Direct of Nursing and Staff Registered Nurses participated in an in-service of the requirements to provide orally and in-writing the disciplines to be provided and the frequency of visits planned at the time of admission. The Director of Nursing will be responsible for monitoring this as an ongoing responsibility to prevent this deficiency from recurring.</p>		

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	<p>(B) Treated with dignity.</p> <p>Based on agency document review and interview, the agency failed to ensure the patient was notified orally and in writing of their right to be treated with dignity for 5 of 5 clinical records reviewed (1-5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home observation on 4-21-15 at 8:30 AM to patient 2, it was noted the patient's admission packet contained agency document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify the patient of her right to be treated with dignity. 2. Patient admission packet reviewed on 4-20-15 evidenced a document "All Ages Home Health Care Inc. Patient Bill of Rights" that failed to notify patient of the right to be treated with dignity. 3. CR 1, SOC, 11-14-14, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of the right to be treated with dignity. 4. CR 3, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of the right to be treated 	N 512	The Patient Bill of Rights for All Ages Home Health Care, Inc. has been revised. Both the State of Indiana Regulations and the Federal Guidelines for Patient Rights were incorporated verbatim, thereby guaranteeing the patient and/or their family will be notified orally and in writing of the right to be treated with dignity. All currently active patients have received a copy of the new Patient Bill of Rights and signed a receipt along with an explanation of the document. A copy has been placed in the home file and office chart of all active patients. All subsequent patient admissions will contain the new Patient Bill of Rights to prevent a recurrence of this deficiency.	05/11/2015			

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N 522 Bldg. 00	<p>with dignity.</p> <p>5. CR 4, SOC, 2-3-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of the right to be treated with dignity.</p> <p>6. CR 5, SOC, 1-19-15, evidenced a document "All Ages Home Health Care, Inc, Patient Bill of Rights" that failed to notify patient of the right to be treated with dignity.</p> <p>7. On 4-20-15 at 11:00 AM, the demonstrator, Employee A, indicated all the agency packets prepared and provided to patients failed to notify patients of the right to be treated with dignity.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p>			N 522	The Director of Nursing will be		05/20/2015

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	<p>Based on policy review, clinical record review, and interview, the agency failed to ensure visits were furnished as ordered on the plan of care in 2 of 3 active patient records reviewed (1, 2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Plan of Care", last reviewed/reviewed 6-9-14, states " Home Care services are furnished under the supervision and direction of the client's physician." 2. Clinical record (CR) 1, start of care 11-14-14, contained a physician's plan of care for certification period 3-14-15 to 5-13-15 with orders for skilled nursing and physical therapy services. Physical therapy (PT) was to visit 1 time each week for 9 weeks. The week of 4-5 to 4-11-15, the clinical record failed to evidence a PT visit was made. The missed visit form in the clinical record dated 4-1-15 evidenced the patient had other appointments and requested PT not come that day. The visit was not rescheduled and the clinical record failed to evidence the physician had been notified of this deviation from the visit frequency ordered on the plan of care. 3. CR 2, start of care 3-3-15, contained a physician's plan of care for certification 		<p>responsible for monitoring the visit scheduled for each patient in accordance with the physician's orders and Plan of Care. All missed visits will be documented and the physician notified. A notation was placed in the chart noting the missed visit by the Physical Therapist as a late entry. A notation of the missed visit by the Home Health Aide of 03/17/2015, 03/31/2015 and 04/07/2015 were documented as a late entry. The Director of Nursing will prevent the recurrence of this deficiency through weekly monitoring of patient's Plan of Care visits ordered and verification of these visits or documentation of missed visits and notification of the patient's physician.</p>				

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N 524	<p>period 3-3-15 to 5-3-15 with orders for home health aide services 2 times a week for 9 weeks. The record failed to evidence home health aide services were conducted on 3-17-15, 3-31-15, and 4-7-15 and the record failed to evidence documentation of the patient's notification prior to the missed visits or that the physician had been notified of the deviation from visit frequency ordered on the plan of care.</p> <p>4. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated 3 home health aide visits had been missed during the certification period for patient in CR 2. She indicated the clinical record failed to evidence the patient had been contacted prior to the missed visit to ensure patient's needs would be met, and failed to evidence the attending physician had been notified home health aide visits had not been furnished according to plan of care orders. For CR 1, the missed visit form failed to document the physician had been notified of the missed visit the week of 4-5 to 4-11-15. She indicated the attending physicians had not been notified in either case.</p>						
	410 IAC 17-13-1(a)(1)						

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Bldg. 00	<p>Patient Care</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on policy review, observation, clinical record review, and interview, the agency failed to ensure all durable medical equipment in the home was included on the plan of care for 4 of 8 active clinical records reviewed (1, 2, 3, 8), failed to ensure the plan of care identified the patient's nutritional requirements for 2 of 3 active records reviewed (1, 7), failed to ensure the</p>	N 524	<p>Items #1, 2, 3, 4 The Director of Nursing in-serviced the staff on the requirement to document all durable medical equipment and assistive devices on patient admission and the office to be advised of any additions by the staff in the home. Items #1, 2, 5 Staff was also in-serviced on the vital need to document nutritional requirements on the Plan of Care. Sited was the example of a staff member "filling in" for the patient's regular caregiver and being unaware of specific dietary needs if not documented. Items</p>	05/11/2015
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	<p>certification period was correctly identified for 1 of 10 clinical records reviewed (8), failed to ensure an order for oxygen was on the plan of care for 1 of 1 clinical records reviewed of patients using oxygen therapy (8), and failed to ensure specific wound care orders were included on the plan of care prior to furnishing wound care for 1 of 1 clinical records reviewed of patients receiving wound care (2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Plan of Care", last reviewed/reviewed 6-9-14, states, "The Plan of Care shall be completed in full to include: specific dietary or nutritional requirements or restrictions ... medical supplies and equipment needed ... medications, treatments, and procedures ... other appropriate items." 2. During home observation on 4-20-15 at 4:45 PM to patient #1, start of care (SOC) 11-14-14, a cane was observed in the home which the patient used during the observation. The clinical record (CR) contained a plan of care (POC) for the 		<p>#1, 6 The staff was in-serviced on the fact that oxygen is considered a medication and must be documented as a type of vehicle to provide oxygen (method of delivery), if by mask or nasal cannula, liters per minute, usage per day, oxygen safety and all these facets documented by a doctor's order and on the Plan of Care. The professional staff was in-serviced on the requirement to document with a physician's order for the specific wound care ordered and any changes in wound care per physicians order. The Director of Nursing will be responsible for reviewing patient care plans and physician's orders on a weekly basis and securing Physician's Order for care changes as needed on each patient to prevent recurrence of this deficiency.</p>				

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	<p>certification period 3-14-15 to 5-14-15 that failed to evidence patient's cane as durable medical equipment and failed to evidence the patient's nutritional requirements.</p> <p>3. During home observation on 4-21-15 at 8:30 AM to patient # 2, SOC 3-3-15, a cane was observed in the home which the patient stated she uses occasionally to ambulate. CR 2 contained a POC for the certification period 3-3-15 to 5-3-15, with orders for SN and home health aide services that failed to evidence patient's cane as durable medical equipment. The registered nurse, Employee E, was observed to furnish wound care to gluteal fold area including, cleansing the area with chlorhexadine, drying, measuring wound, applying calcium alginate 4 x 4 inch dressing, and securing with tape. CR 2 evidenced a physician's order for "skilled nursing visits 1-3 times a week to treat pressure sore-decubitus on area of gluteal fold coccyx." The plan of care failed to evidence specific orders for wound care. Employee E performed wound care on 3-13, 3-17, 3-10, 3-24, 3-27, 3-31, 4-3, 4-8, 4-10, 4-15, 4-17, and</p>			

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	<p>4-21-2015.</p> <p>4. During home observation on 4-21-15 at 5:15 PM to Patient 3, a shower/bath chair was observed in the bathroom. The patient's spouse indicated the patient used this to shower/bathe. The POC for the certification period 4-4 to 6-3-15 failed to evidence the bath/shower chair as durable medical equipment.</p> <p>5. CR 7, SOC 4-1-15, contained a POC for the certification period 4-1 to 6-3-15 that failed to evidence the patient's nutritional requirements.</p> <p>6. CR 8, SOC 1-15-15. contained a POC for the certification period 4-9- (resumption of care date) to 6-8-15. The patient had a single episode of care which evidenced a transfer of care on 3-12-15 and resumption of care on 4-9-15. The POC evidenced an oxygen concentrator as durable medical equipment (DME). The POC failed to evidence a tub/shower chair as DME. The occupational therapy (OT) visit note from 4-11-15 evidenced tub/shower chair as DME. OT note dated 1-15-15 evidenced patient uses oxygen at 2 liters per minute, per nasal cannula, via an oxygen concentrator as needed for dyspnea. The POC failed to evidence tub/shower chair as durable medical equipment and failed to evidence a physician's order for oxygen, indications</p>			

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N 541 Bldg. 00	<p>for use (continuous or as needed), the setting of liters per minute, and the method of delivery.</p> <p>7. On 4-22-15 at 2:15 PM and 5-4-15 at 4:00 PM, the administrator, Employee A, indicated CR 1, 2, 3, and 8 should have included all the durable medical equipment in the patients' homes, and CR 1 and 7 should have included patient's nutritional requirements. Employee B indicated she had failed to obtain a wound care order clarification to include specific order for cleansing and dressing materials for Patient 2. The administrator indicated CR 8 had incorrect dates for the patient's first re-certification period, which should have been 3-16-15 to 5-14-15; failed to list all the DME in the home; and failed to include a physician's order for oxygen therapy. Employee B, nursing supervisor, indicated she had erroneously changed the certification period for CR 8 to coincide with the resumption of care date.</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on policy review, clinical record</p>	N 541	The Agency has purchased and	05/11/2015			

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	<p>review, and interview, the agency failed to ensure the comprehensive assessment was updated to include re-assessment of risk for pressure ulcer at re-certification for 1 of 4 clinical records reviewed of patients receiving care 60 days or more (3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy "Comprehensive Client Assessment" , last reviewed/revised 6-9-14, states, "In addition to general health status/system assessment, the agency comprehensive assessment tool with OASIS will include: Integumentary status, Pressure ulcer risk assessment ... Reassessments are conducted based on ... regulatory requirement ... " Clinical record 3, start of care 2-3-15, contained a follow-up (re-certification) comprehensive assessment dated 4-3-15 that failed to evidence an assessment of pressure ulcer risk. On 4-22-15 at 2:15 PM, the administrator, Employee A, and nursing supervisor, Employee B, indicated the agency uses the Braden assessment tool to determine risk of pressure ulcer. Clinical Record 3 follow-up assessment dated 4-3-15 did not include a pressure 				<p>is currently using the entire Briggs OASIS forms series which provides a more comprehensive assessment. The professional staff was in-serviced on the requirement on each Admission, Resumption of Care, Re-evaluation and 60 Day Recertification to include a Tinetti, Braden Scale, Safety Measures, Pain Evaluation and any other teaching deemed necessary and documentation of same. The Director of Nursing will monitor professional documentation as an ongoing function when it is submitted to prevent this deficiency from recurring.</p>		

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N 543 Bldg. 00	<p>ulcer risk re-assessment which should have done by the registered nurse as required by agency policy.</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on policy review, observation, clinical record review, and interview, the agency failed to ensure the registered nurse implemented preventative and evaluative nursing measures for 3 of 3 active records reviewed (1, 2, 3).</p> <p>Findings include:</p> <p>1. Agency policy "Skilled Nursing Services", reviewed/reviewed 6-9-14, states "The registered nurse: ... Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures."</p> <p>2. On 4-20-15 12/12/14 at 4:45 PM, a home visit was made to patient 1. The patient was observed to have an abnormal gait. Clinical record (CR)1, start of care (SOC) 11-14-14, contained a plan of care (POC) for the certification period 3-14 to</p>	N 543	The Staff was in-serviced on the need for the implementation of safety measures on all patients on admission and updated as needed with patient care changes and needs changes per direction of the Director of Nursing the staff will now complete a Tinetti Evaluation, Braden Scale, Pain Evaluation and any other safety measure updates with each recertification and re-evaluation in addition to being completed on and as needed basis. The Director of Nursing is responsible for ongoing monitoring of patient care and safety measures evaluation to prevent recurrence of the deficiency.	05/11/2015

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	<p>5-13-15, with orders for skilled nursing (SN) 1 time per week to include set up medications, monitor vital signs and physical therapy (PT) to include upper and lower body strengthening. The area of the POC "safety measures" was blank.</p> <p>3. On 4-21-15 at 8:30 AM, a home observation was made to patient 2. The patient used a walker or a cane to ambulate. The patient indicated in conversation with RN, Employee E, she had fallen in her kitchen and broken her hip shortly before coming on service with the agency. The POC for the certification period of 3-3 to 5-3-15 failed to evidence safety measures.</p> <p>4. During home observation on 4-21-15 at 5:15 PM to patient 3, a shower/bath chair was observed in the bathroom of the home. The spouse of patient 3 indicated patient 3 used this to shower/bathe because he was weak and unsteady on his feet. The POC for the certification period 4-4 to 6-3-15 failed to evidence any "safety measures."</p> <p>5. On 4-22-15 at 2:15 PM, Employee A, administrator, and Employee B, nursing supervisor, indicated the RN should have implemented fall precautions as safety measures for patients 1 -3.</p>			

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N 550 Bldg. 00	<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 observation, clinical record review, and interview, the agency failed to ensure the home health aide (HHA) care plan included the frequency for HHA duties for 1 of 1 active patients receiving HHA (2) services the HHA care plan included the patient's nutritional requirements for 1 of 1 active records reviewed of patients receiving HHA services (2).</p> <p>Findings include:</p> <p>1. HHA care plan for patient #2, dated 2-26-15, evidenced HHA duties of bed bath, shampoo, walking, transfer, reposition, and dressing upper and lower. The written HHA instructions failed to evidence a frequency for the duties of bed bath, shampoo, hair care, and skin care.</p> <p>3. On 4-22-15 at 2:15 PM, the administrator, Employee A, and the nursing supervisor, Employee B, indicated the HHA care plan for patient 2</p>			N 550	<p>The professional staff was in-serviced on the correct completion of the Home Health Aide Care Plan to include frequency of duties assigned. Included in the in-servicing was the need to do a Change of Care documentation as required by the patient status and make the appropriate changes in the Home Health Aide Plan of Care and educate the Home Health Aide of any changes. The Director of Nursing is responsible for monitoring patient care and conferencing with other professional staff to determine specific patient needs and instituting the appropriate changes and securing physicians orders to such as needed. By doing this, the Director of Nursing will prevent recurrence of this deficiency.</p>		05/11/2015

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N 566 Bldg. 00	<p>did not include the frequency of duties.</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;</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the occupational therapist's (Employee G) evaluation included objective measurement of function for 2 of 6 patients receiving therapy services (3, 8).</p> <p>Findings include:</p> <p>1. Agency policy "Therapy Services" , last reviewed/revised 6-9-14, states "Measurable treatment goals will be described in the the plan of care and the patient's clinical record would determine that the method used to assess a patient's function would include objective measurement and successful comparison of measurements, thus enabling objective measurement or progress towards goals and/or therapy effectiveness."</p> <p>2. Clinical record (CR) 3, start of care</p>			N 566	<p>The Therapy Staff was in-serviced on the need to do objective measurements and comparison of measurements. All measurements need to be specific and show progress toward goals or regression if patient condition is deteriorating. The Director of Nursing will be responsible for reviewing Therapy notes on a weekly basis to advise therapist if items are lacking to prevent recurrence of this deficiency.</p>		05/11/2015

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	<p>2-3-15, contained a plan of care for the certification period 4-4 to 6-3-15, with orders for occupational therapy (OT) 1-2 times per week for 9 weeks for cognitive training, upper body strengthening exercises, balance training, and educate wife to assist husband safely. Start of care OT evaluation dated 2-9-15 failed to include muscle strength against gravity measurements and range of motion measurements.</p> <p>3. CR 8, SOC 1-15-15, contained a POC for the certification period 4-9 to 6-8-15 with order for OT 1-2 times per week for 9 weeks for upper body strengthening, teach body mechanics to reduce pain and SOB (sic shortness of breath), and improve ability to perform ADLs (sic activities of daily living). Evaluation by OT dated 1-15-15 failed to evidence range of motion and mobility measurements. Evaluation by OT dated 4-11-15 failed to evidence range of motion and mobility measurements.</p> <p>4. On 4-22-15 at 2:15 PM and 5-4-15 at 4:00 PM, Employee A, administrator, and Employee B, nursing supervisor, indicated the OT therapy evaluation note</p>			

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N 612 Bldg. 00	<p>at SOC for patient 3 did not include objective functional measurements to provide a basis of determining progress towards goals and/or therapy effectiveness, as required by agency policy. For CR 8, the OT evaluations dated 1-15-15 and 4-11-15 did not include objective functional measurements to provide a basis of determining progress towards goals and/or therapy effectiveness, as required by agency policy.</p> <p>410 IAC 17-15-1(b) Clinical Records Rule 15 Sec. 1(b) Original clinical records shall be retained for the length of time as required by IC 16-39-7 after home health services are terminated by the home health agency. Policies shall provide for retention even if the home health agency discontinues operations.</p> <p>Based on policy review, review of IC 16-39-7, and interview, the agency failed to ensure its clinical records policy was in accordance with IC 16-39-7, which requires home health agencies to retain clinical records for at least 7 years, for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. Agency policy "Clinical Records/Medical Record Retention", last</p>	N 612	The policy on Retention of Records was in error stating in one area six (6) years and in another area seven (7) years. The Policy has been corrected to read seven (7) years for Record Retention in all areas. This will prevent recurrence of the deficiency. The Administrator will be responsible for ongoing monitoring of this policy to promote adherence.	05/11/2015

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	<p>reviewed/revised 6-9-14 states, clinical records shall be retained for six (6) years after the month of the cost report to which the records apply is filed with the intermediary, or for such a period of time as specified by state laws."</p> <p>2. Indiana Code 16-39-7 states it applies to "A home health agency licensed under IC 16-27" and "A provider (sic health care provider) shall maintain the original health records or microfilms of the records for at least seven (7) years."</p> <p>3. On 4-22-15 at 2:15 PM, the administrator, Employee A, indicated the agency policy should be interpreted to require retention of records for 7 years, as 6 years after the month of the cost report is filed with the intermediary would be 7 years.</p>			