

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/26/2013
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NAME OF PROVIDER OR SUPPLIER  SERVANT'S HEART HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSPORT, IN 46947
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G000000	<p>This was a federal home health complaint investigation.</p> <p>Complaint # IN 00125245 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey Date: March 26, 2013</p> <p>Facility #: 011301</p> <p>Medicaid Vendor #: 200852690</p> <p>Surveyors: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">April 1, 2013</p>	G000000		

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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G000106	<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 policy, clinical record, and administrative document review and interview, the agency failed to follow their own policy and acknowledge complaints and grievances voiced by patients, family members, and care givers regarding a lack of respect of the patient's property and lack of treatment received for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include:</p> <p>1. Review of the undated policy titled "Patient's Rights and Responsibilities / Grievance Procedure" states, "Servant's Heart Home Health Services will investigate complaints made by a client / family member or guardian regarding care or treatment furnished or that was not furnished. The agency will investigate complaints made identifying a lack of respect for client property by anyone providing services on behalf of the agency. The agency will document the</p>	G000106	<p>All staff will be given a written in-service on 4-15-13 regarding the importance of reporting any complaints to the Administrator and/or Director of Nursing as soon as they are received. Complaints will be investigated within 24 hours of the time they are received, and they will be resolved as quickly as possible, but no longer than 7 days after receiving the complaint. Should the complaint take longer than 30 days to be resolved, it will be reviewed by the Professional Advisory Board for resolution. We have developed a new process for documenting complaints using our web based program (Health Care Strategies Connect) which we also utilize for most of our clinical documentation, such as Plan Of Cares, Verbal Orders, etc. Complaints will be entered into a Communication Log in HCS, and will be titled "COMPLAINT". The format for this Complaint Log will allow us to document the patient's concerns, the employee's comments, the result of our investigation, and any corrective</p>	04/30/2013			

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	<p>existence of a complaint and the resolution. The documentation will be placed in a confidential "Complaint" file. If client verbalizes a complaint to the agency staff in the home the complaint will be documented and communicated to the director of nursing / designee who will investigate the complaint in a manner consistent with the nature of the complaint."</p> <p>2. On 3/26/13 at 11 AM the administrator indicated that the agency had incidents and no patient complaints and the documentation was not current and up to date.</p> <p>3. Clinical record 2 evidenced a document titled "Home Health Patient Discharge Sheet" dated 2/12/13 and authored by the administrator which states, "Unfortunately [patient] has complained on multiple occasions about the services we are providing. [patient] has made the following complaints: 1. We have taken 2 months to provide ROM [range of motion] with the aides (This complaint is not accurate)." Another document titled "Patient Case Conference / Coordination of Care" dated 2/12/13 stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complains."</p>		<p>action that needs to be taken. All complaints will be printed and placed in a notebook which will be maintained by the Administrator. The Administrator will be responsible for monitoring and investigating any complaints. A monthly audit will be performed by the Administrator to verify that all complaints have been logged, investigated, and resolved in a timely manner, and to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>4. Agency documentation evidenced patient care concerns / complaints by the following:</p> <p>A. On 3/26/13 at 12:45 PM, the administrator provided an administrative document dated 1/4/13. The document indicated the caregiver for patient 6 made allegation to the administrator that a home health aide, employee E, had stolen money and gift cards form the home. The document failed to evidence the agency investigated the complaint and followed through. The document evidenced the employee was no longer assigned to patient 6 and the local police department was called by the patient's caregiver.</p> <p>B. At 5:26 PM, the administrator provided documentation which evidenced multiple complaints regarding the aide services provided by employee E dated 10/25/12, 1/31/13, and 2/19/13. The complaints included the employee spending time on a personal cell phone while on duty, tasks not completed and observed by the skilled nurse completing the supervisory visits, and a report that the aide had not completed bathing and skin care tasks and noted by agency staff.</p>			

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G000107	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on policy, clinical record, and administrative document review and interview, the agency failed to follow their own policy to investigate complaints and document the existence and the resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include:</p> <p>1. Review of the undated policy titled "Patient's Rights and Responsibilities / Grievance Procedure" states, "Servant's Heart Home Health Services will investigate complaints made by a client / family member or guardian regarding care or treatment furnished or that was not furnished. The agency will investigate complaints made identifying a lack of respect for client property by anyone providing services on behalf of the agency. The agency will document the</p>	G000107	<p>All staff will be given a written in-service on 4-15-13 regarding the importance of reporting any complaints to the Administrator and/or Director of Nursing as soon as they are received. Complaints will be investigated within 24 hours of the time they are received, and they will be resolved as quickly as possible, but no longer than 7 days after receiving the complaint. Should the complaint take longer than 30 days to be resolved, it will be reviewed by the Professional Advisory Board for resolution.</p> <p>We have developed a new process for documenting complaints using our web based program (Health Care Strategies Connect) which we also utilize for most of our clinical documentation, such as POC's, VO's, etc.</p> <p>Complaints will be entered into a Communication Log in HCS, and will be titled "COMPLAINT". The format for this Complaint Log will allow us to document the</p>	04/15/2013			

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	<p>existence of a complaint and the resolution. The documentation will be placed in a confidential "Complaint" file. If client verbalizes a complaint to the agency staff in the home the complaint will be documented and communicated to the director of nursing / designee who will investigate the complaint in a manner consistent with the nature of the complaint."</p> <p>2. On 3/26/13 at 11 AM the administrator indicated that the agency had incidents and no patient complaints and the documentation was not current and up to date.</p> <p>3. Clinical record 2 evidenced a document titled "Home Health Patient Discharge Sheet" dated 2/12/13 and authored by the administrator which states, "Unfortunately [patient] has complained on multiple occasions about the services we are providing. [patient] has made the following complaints: 1. We have taken 2 months to provide ROM [range of motion] with the aides (This complaint is not accurate)." Another document titled "Patient Case Conference / Coordination of Care" dated 2/12/13 stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complains."</p>		<p>patient's concerns, the employee's comments, the result of our investigation, and any corrective action that needs to be taken. All complaints will be printed and placed in a notebook which will be maintained by the Administrator. The Administrator will be responsible for monitoring and investigating any complaints. A monthly audit will be performed by the Administrator to verify that all complaints have been logged, investigated, and resolved in a timely manner, and to ensure that this deficiency is corrected and will not recur.</p>	

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G000159	<p><b>484.18(a)</b> <b>PLAN OF CARE</b></p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the physician ordered plan of care included the specific interventions to be provided in 1 (# 2) of 5 records reviewed of patients that received aide services creating the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a document titled "Home Health Aide Assignment Sheet" dated 11/30/12 and updated on 1/31/13 that stated, "Assist with ROM [range of motion] exercise."</p> <p>A. The record evidenced employees D, G, H, and I provided aide services between 12/4/12 through 2/16/13. The aide visits were documented by the</p>	G000159	The RN Case Managers and supervising nurses will meet with the Administrator on 4-8-13 for education on noting Range of Motion on the Plan of Care and on the Home Health Aide assignment sheets. A chart audit for every patient will be conducted by 4-30-13. The Administrator, the Director of Nurses, and the R.N. Case Managers will perform the audit and verify that the aides are providing and documenting ROM when appropriate for every patient. All Home Health Aides will be educated with a written in-service on 4-15-13 regarding providing and documenting Range of Motion and on the importance of following the Home Health Aide assignment sheet for each patient. 10 % of all clinical records will be audited every 30 days for evidence that the Range of Motion is being provided and documented appropriately, and that Range of Motion is noted on the Plan of Care for any patient receives this service. The	04/30/2013	

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	<p>individual completing the daily services and none of the aide visit notes contained documentation that the aide provided the range of motion that was assigned or identified why is was not completed.</p> <p>B. The record included plans of care established by the physician for the certification periods 12/4/12 through 2/1/13 and 2/2/13 through 4/2/13. The plans of care stated, "HHA 7 Week 9 [7 days per week for 9 weeks] Home Heath Aide assistance twice daily for 2 hours each visit, 7 days / week to help with bathing / personal care needs, meal prep, provide medication reminders, monitor safety, perform light housekeeping, and assist with ADL's [Activities of Daily Living]/ IADL's [Instrumental Activities of Daily Living] X 60 days." The plans of care failed to evidence an order for the aide to complete any range of motion with the patient, actively or passively.</p> <p>2. At 4:40 PM on 3/26/13, employee A indicated the agency obtains physician orders for all patients that receive services including those that receive aide only services and did not have nurse directed care plans.</p> <p>3. The undated policy titled "Care Plans C - 660" stated, "Each client will have a care plan on file that addresses their</p>		Administrator and Director of Nurses will be responsible for monitoring these chart audits and will ensure that this deficiency is corrected and will not recur.	

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	<p>identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals. Following the initial assessment, a care plan shall be developed with the client and / or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care. ... The care plan shall include, but not be limited to: ... A list of specific interventions with plans for implementation."</p>			

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G000224	<p>484.36(c)(1) ASSIGNMENT &amp; 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 clinical record review and interview, the agency failed to ensure the registered nurse who completed the home health aide care plan only included those services ordered on the plan of care in 1 (# 2) of 5 records reviewed of patients that received aide services creating the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a document titled "Home Health Aide Assignment Sheet" dated 11/30/12 and updated on 1/31/13 that stated, "Assist with ROM [range of motion] exercise."</p> <p>A. A document titled "Patient Case Conference / Coordination of Care" dated 2/12/13 stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complaints."</p>	G000224	The RN Case Managers and supervising nurses will meet with the Administrator on 4-8-13 for education on noting Range of Motion on the Plan of Care and on the Home Health Aide assignment sheets. A chart audit for every patient will be conducted by 4-30-13. The Administrator, the Director of Nurses, and the R.N. Case Managers will perform the audit and verify that the aides are providing and documenting ROM when appropriate for every patient. All Home Health Aides will be educated with a written in-service on 4-15-13 regarding providing and documenting Range of Motion and on the importance of following the Home Health Aide assignment sheet for each patient. 10 % of all clinical records will be audited every 30 days for evidence that the Range of Motion is being provided and documented appropriately, and that Range of Motion is noted on the Plan of Care for any patient receives this service. The Administrator and Director of Nurses will be responsible for monitoring these chart audits and will ensure that this deficiency is	04/30/2013			

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	<p>B. The record included plans of care established by the physician for the certification periods 12/4/12 through 2/1/13 and 2/2/13 through 4/2/13. The plans of care stated, "HHA 7 Week 9 [7 days per week for 9 weeks] Home Heath Aide assistance twice daily for 2 hours each visit, 7 days / week to help with bathing / personal care needs, meal prep, provide medication reminders, monitor safety, perform light housekeeping, and assist with ADL's [Activities of Daily Living]/ IADL's [Instrumental Activities of Daily Living] X 60 days." The plans of care failed to evidence an order for the aide to complete any range of motion with the patient, actively or passively.</p> <p>2. At 4:40 PM on 3/26/13, employee A indicated the agency obtains physician orders for all patients that receive services including those that receive aide only services and did not have nurse directed care plans.</p>		corrected and will not recur.		

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G000230	<p><b>484.36(d)(3) SUPERVISION</b></p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse made supervisory visits every 30 days as required by agency policy in 1 of 3 records reviewed of patients receiving home health aide only services for 30 days or more with the potential to affect all patients who receive home health aide only services. (2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 2, start of care 12/4/12, evidenced a plan of care dated 12/4/12 through 2/1/13 with orders for home health aide services daily 7 days a week. The record evidenced the first aide service was provided on 12/4/12. The record failed to evidence a supervisory visit of the home health aide services until 1/31/13.</li> <li>An undated policy titled "Supervision</li> </ol>	G000230	<p>After investigating this deficiency, we found that the problem revolved more around confusion of the actual due date and not the regulations for when they should be done. The nurses are all aware of the regulations for when the visits are due. However, some visits were being done late because the previous Supervisory Visit was done earlier than scheduled, throwing off the due date for the next scheduled visit. The Administrator now maintains a spreadsheet with the due dates for Supervisory Visits for every patient. This spreadsheet will be reviewed and updated weekly by the Administrator and/or Director of Nurses. The due dates will be entered on the nurses' work schedule by the Administrator and/or Director of Nurses to make sure the visits are done in a timely manner. (This is a web based scheduling program that can be accessed by all the nurses and managers and can be used as a communication tool for all</p>	04/08/2013			

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	<p>of Staff" C-315 states, "2. If clients are receiving only home health aide services and there is no skilled service provided, a registered nurse will make a supervisory visit while the aide is providing care, at least once every 60 days, or per State / Agency guidelines." State rules require a visit every 30 days.</p> <p>3. On 3/25/13 at 5 PM, during the clinical record review of record # 2, the assistant director of nursing indicated the supervisory visits were conducted at 60 day intervals with the reevaluation of the patient.</p>		<p>staff.) If the visit is done earlier than the required due date, the RN doing that visit will report it to the Administrator in order to keep the schedule updated appropriately. In addition to this, all Supervisory Visits will be noted on the schedule after they are done to facilitate communication and to maintain the correct schedule for the next required Supervisory Visit. The schedule for all Supervisory visits will be monitored by the Administrator and/or Director of Nurses on a weekly (if not daily) basis. 10% of all charts will be audited every 30 days to ensure that the Supervisory Visits are done on time and prevent this deficiency from recurring again.</p>	

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G000334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the comprehensive assessment was completed after the start of care in 1 of 5 clinical records reviewed of patients receiving aide services and requiring a comprehensive assessment. (# 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record review 2, state of care 12/4/12, included a start of care assessment dated 11/30/12. The patient received the first services on 12/4/12.</li> <li>2. On 3/26/13 at 5:00 PM, during the clinical record review of the clinical record 2, the administrator indicated initial comprehensive assessment dated 11/30/12 and the patient received services beginning 12/4/12.</li> </ol>	G000334	<p>We request an informal dispute regarding this tag. The Start of Care date was 12/4/12, and our Comprehensive Assessment was done 11/30/12, which was four days before we started care for this patient. In order to correct this deficiency, we will re-educate all of our nurses that the Comprehensive Assessment must be done in a timely manner consistent with the patient's needs but no later than 5 days after the SOC.</p> <p>10 % of all clinical records will be audited by April 30, 2013 and then every 30 days for evidence that Comprehensive Assessments are being done in a timely manner.</p> <p>The Administrator and Director of Nurses will beresponsible for monitoring these chart audits and will ensure that thisdeficiency is corrected and will not recur.</p>	04/30/2013	

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G000337	<p><b>484.55(c)</b> <b>DRUG REGIMEN REVIEW</b> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record review and interview, the agency failed to ensure the comprehensive reassessment included a review of all medications for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance in 1 of 5 clinical records reviewed of patients receiving aide services and requiring a comprehensive assessment. (# 2)</p> <p>Findings:</p> <p>1. Clinical record review 2, state of care 12/4/12, failed to identify a review of all medications had been performed at the comprehensive assessment dated 11/30/12.</p> <p>2. On 3/26/13 at 5:00 PM, during the clinical record review of the clinical record 2, the administrator indicated the list of medications was to be printed and signature would indicate the medications were reviewed and that the record did not</p>	G000337	<p>This deficiency occurred because the medication review had been completed on our web based computer program (HCS) when we developed the patient's Plan of Care on the Admission Assessment, but we failed to print out the Medication Log for the paper documentation in the patient's chart until the re-certification period 60 days later. Therefore, the date on the Medication Log in the patient's chart was 60 days after the Start of Care date. In order to prevent this from happening again, the nurses were all informed of this oversight during a meeting on 4-8-13, and informed of the importance of printing off the paper copy of the patient's records fort heir file every time the patient's medications are reviewed. By April 30, 2013, every chart will be audited by the RN Case Managers, the Administrator, the Director of Nurses and the Assistant Director of Nurses to ensure that the Medication Review has been completed and that the Medication Log is printed and in</p>	04/08/2013

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N000000	<p>evidence the medication review for the initial comprehensive assessment dated 11/30/12.</p> <p>This was a state home health complaint investigation.</p> <p>Complaint # IN 00125245 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey Date: March 26, 2013</p> <p>Facility #: 011301</p> <p>Medicaid Vendor #: 200852690</p> <p>Surveyors: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 1, 2013</p>	N000000	the patient's file. 10% of all charts will be audited every 30 days to ensure that medication reviews have been performed for each patient and that the Medication Logs are printed and updated every 60 days.		

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N000500	<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 policy, clinical record, and administrative document review and interview, the agency failed to follow their own policy and acknowledge complaints and grievances voiced by patients, family members, and care givers regarding a lack of respect of the patient's property and lack of treatment received for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include:</p> <p>1. Review of the undated policy titled "Patient's Rights and Responsibilities / Grievance Procedure" states, "Servant's Heart Home Health Services will investigate complaints made by a client / family member or guardian regarding care or treatment furnished or that was not furnished. The agency will investigate</p>	N000500	All staff will be given a written in-service on 4-15-13 regarding the importance of reporting any complaints to the Administrator and/or Director of Nursing as soon as they are received. Complaints will be investigated within 24 hours of the time they are received, and they will be resolved as quickly as possible, but no longer than 7 days after receiving the complaint. Should the complaint take longer than 30 days to be resolved, it will be reviewed by the Professional Advisory Board for resolution. We have developed a new process for documenting complaints using our web based program (Health Care Strategies Connect) which we also utilize for most of our clinical documentation, such as POC's, VO's, etc. Complaints will be entered into a Communication Log in HCS, and will be titled "COMPLAINT". The format for this Complaint Log will allow us to document the patient's	04/15/2013			

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	<p>complaints made identifying a lack of respect for client property by anyone providing services on behalf of the agency. The agency will document the existence of a complaint and the resolution. The documentation will be placed in a confidential "Complaint" file. If client verbalizes a complaint to the agency staff in the home the complaint will be documented and communicated to the director of nursing / designee who will investigate the complaint in a manner consistent with the nature of the complaint."</p> <p>2. On 3/26/13 at 11 AM the administrator indicated that the agency had incidents and no patient complaints and the documentation was not current and up to date.</p> <p>3. Clinical record 2 evidenced a document titled "Home Health Patient Discharge Sheet" dated 2/12/13 and authored by the administrator which states, "Unfortunately [patient] has complained on multiple occasions about the services we are providing. [patient] has made the following complaints: 1. We have taken 2 months to provide ROM [range of motion] with the aides (This complaint is not accurate)." Another document titled "Patient Case Conference / Coordination of Care" dated 2/12/13</p>		<p>concerns, the employee's comments, the result of our investigation, and any corrective action that needs to be taken. All complaints will be printed and placed in a notebook which will be maintained by the Administrator. The Administrator will be responsible for monitoring and investigating any complaints. A monthly audit will be performed by the Administrator to verify that all complaints have been logged, investigated, and resolved in a timely manner, and to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complaints."</p> <p>4. Agency documentation evidenced patient care concerns / complaints by the following:</p> <p>A. On 3/26/13 at 12:45 PM, the administrator provided an administrative document dated 1/4/13. The document indicated the caregiver for patient 6 made allegation to the administrator that a home health aide, employee E, had stolen money and gift cards form the home. The document failed to evidence the agency investigated the complaint and followed through. The document evidenced the employee was no longer assigned to patient 6 and the local police department was called by the patient's caregiver.</p> <p>B. At 5:26 PM, the administrator provided documentation which evidenced multiple complaints regarding the aide services provided by employee E dated 10/25/12, 1/31/13, and 2/19/13. The complaints included the employee spending time on a personal cell phone while on duty, tasks not completed and observed by the skilled nurse completing the supervisory visits, and a report that the aide had not completed bathing and</p>			

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N000514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on policy, clinical record, and administrative document review and interview, the agency failed to follow their own policy to investigate complaints and document the existence and the resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include:</p> <p>1. Review of the undated policy titled "Patient's Rights and Responsibilities / Grievance Procedure" states, "Servant's Heart Home Health Services will investigate complaints made by a client / family member or guardian regarding care or treatment furnished or that was not furnished. The agency will investigate</p>	N000514	All staff will be given a written in-service on 4-15-13 regarding the importance of reporting any complaints to the Administrator and/or Director of Nursing as soon as they are received. Complaints will be investigated within 24hours of the time they are received, and they will be resolved as quickly as possible, but no longer than 7 days after receiving the complaint. Should the complaint take longer than 30 days to be resolved, it will be reviewed by the Professional Advisory Board for resolution. We have developed a new process for documenting complaints using our web based program (Health Care Strategies Connect) which we also utilize for most of our clinical documentation, such as Plan of Cares, Verbal Orders, etc. Complaints will be entered into a Communication Log in	04/15/2013	

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	<p>complaints made identifying a lack of respect for client property by anyone providing services on behalf of the agency. The agency will document the existence of a complaint and the resolution. The documentation will be placed in a confidential "Complaint" file. If client verbalizes a complaint to the agency staff in the home the complaint will be documented and communicated to the director of nursing / designee who will investigate the complaint in a manner consistent with the nature of the complaint."</p> <p>2. On 3/26/13 at 11 AM the administrator indicated that the agency had incidents and no patient complaints and the documentation was not current and up to date.</p> <p>3. Clinical record 2 evidenced a document titled "Home Health Patient Discharge Sheet" dated 2/12/13 and authored by the administrator which states, "Unfortunately [patient] has complained on multiple occasions about the services we are providing. [patient] has made the following complaints: 1. We have taken 2 months to provide ROM [range of motion] with the aides (This complaint is not accurate)." Another document titled "Patient Case Conference / Coordination of Care" dated 2/12/13</p>		<p>HCS, and will be titled "COMPLAINT". The format for this Complaint Log will allow us to document the patient's concerns, the employee's comments, the result of our investigation, and any corrective action that needs to be taken. All complaints will be printed and placed in a notebook which will be maintained by the Administrator. The Administrator will be responsible for monitoring and investigating any complaints. A monthly audit will be performed by the Administrator to verify that all complaints have been logged, investigated, and resolved in a timely manner, and to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complaints."</p> <p>4. Agency documentation evidenced patient care concerns / complaints by the following:</p> <p>A. On 3/26/13 at 12:45 PM, the administrator provided an administrative document dated 1/4/13. The document indicated the caregiver for patient 6 made allegation to the administrator that a home health aide, employee E, had stolen money and gift cards form the home. The document failed to evidence the agency investigated the complaint and followed through. The document evidenced the employee was no longer assigned to patient 6 and the local police department was called by the patient's caregiver.</p> <p>B. At 5:26 PM, the administrator provided documentation which evidenced multiple complaints regarding the aide services provided by employee E dated 10/25/12, 1/31/13, and 2/19/13. The complaints included the employee spending time on a personal cell phone while on duty, tasks not completed and observed by the skilled nurse completing the supervisory visits, and a report that the aide had not completed bathing and</p>			

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record and policy review and interview, the agency failed to ensure the physician ordered plan of care included the specific interventions to be provided in 1 (# 2) of 5 records reviewed of patients that received aide services creating the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p>	N000524	The RN Case Managers and supervising nurses will meet with the Administrator on 4-8-13 for education on noting Range of Motion on the Plan of Care and on the Home Health Aide assignment sheets. A chart audit for every patient will be conducted by 4-30-13. The Administrator, the Director of Nurses, and the R.N. Case Managers will perform the audit and verify that the aides are providing and documenting ROM when appropriate for every patient. All Home Health Aides	04/30/2013	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Clinical record number 2 included a document titled "Home Health Aide Assignment Sheet" dated 11/30/12 and updated on 1/31/13 that stated, "Assist with ROM [range of motion] exercise."</p> <p>A. The record evidenced employees D, G, H, and I provided aide services between 12/4/12 through 2/16/13. The aide visits were documented by the individual completing the daily services and none of the aide visit notes contained documentation that the aide provided the range of motion that was assigned or identified why it was not completed.</p> <p>B. The record included plans of care established by the physician for the certification periods 12/4/12 through 2/1/13 and 2/2/13 through 4/2/13. The plans of care stated, "HHA 7 Week 9 [7 days per week for 9 weeks] Home Health Aide assistance twice daily for 2 hours each visit, 7 days / week to help with bathing / personal care needs, meal prep, provide medication reminders, monitor safety, perform light housekeeping, and assist with ADL's [Activities of Daily Living]/ IADL's [Instrumental Activities of Daily Living] X 60 days." The plans of care failed to evidence an order for the aide to complete any range of motion with the patient, actively or passively.</p>		<p>will be educated with a written in-service on 4-15-13 regarding providing and documenting Range of Motion and on the importance of following the Home Health Aide assignment sheet for each patient. 10 % of all clinical records will be audited every 30 days for evidence that the Range of Motion is being provided and documented appropriately, and that Range of Motion is noted on the Plan of Care for any patient receives this service. The Administrator and Director of Nurses will be responsible for monitoring these chart audits and will ensure that this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/26/2013
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	<p>2. At 4:40 PM on 3/26/13, employee A indicated the agency obtains physician orders for all patients that receive services including those that receive aide only services and did not have nurse directed care plans.</p> <p>3. The undated policy titled "Care Plans C - 660" stated, "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals. Following the initial assessment, a care plan shall be developed with the client and / or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care. ... The care plan shall include, but not be limited to: ... A list of specific interventions with plans for implementation."</p>			

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse who completed the home health aide care plan only included those services ordered on the plan of care in 1 (# 2) of 5 records reviewed of patients that received aide services creating the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a document titled "Home Health Aide Assignment Sheet" dated 11/30/12 and updated on 1/31/13 that stated, "Assist with ROM [range of motion] exercise."</p> <p>A. A document titled "Patient Case Conference / Coordination of Care" dated 2/12/13 stated, "HHA's [Home Health Aides] are assisting with ROM [Range of Motion]. Pt. [patient] at times is easily agitated and frequently complaints."</p>	N000550	The RN Case Managers and supervising nurses will meet with the Administrator on 4-8-13 for education on noting Range of Motion on the Plan of Care and on the Home Health Aide assignment sheets. A chart audit for every patient will be conducted by 4-30-13. The Administrator, the Director of Nurses, and the R.N. Case Managers will perform the audit and verify that the aides are providing and documenting ROM when appropriate for every patient. All Home Health Aides will be educated with a written in-service on 4-15-13 regarding providing and documenting Range of Motion and on the importance of following the Home Health Aide assignment sheet for each patient. 10 % of all clinical records will be audited every 30 days for evidence that the Range of Motion is being provided and documented appropriately, and that Range of Motion is noted on the Plan of Care for any patient receives this service. The Administrator and Director of Nurses will be responsible for monitoring these chart audits and	04/30/2013

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	<p>B. The record included plans of care established by the physician for the certification periods 12/4/12 through 2/1/13 and 2/2/13 through 4/2/13. The plans of care stated, "HHA 7 Week 9 [7 days per week for 9 weeks] Home Heath Aide assistance twice daily for 2 hours each visit, 7 days / week to help with bathing / personal care needs, meal prep, provide medication reminders, monitor safety, perform light housekeeping, and assist with ADL's [Activities of Daily Living]/ IADL's [Instrumental Activities of Daily Living] X 60 days." The plans of care failed to evidence an order for the aide to complete any range of motion with the patient, actively or passively.</p> <p>2. At 4:40 PM on 3/26/13, employee A indicated the agency obtains physician orders for all patients that receive services including those that receive aide only services and did not have nurse directed care plans.</p>		will ensure that this deficiency is corrected and will not recur.		

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse made supervisory visits every 30 days as required by agency policy in 1 of 3 records reviewed of patients receiving home health aide only services for 30 days or more with the potential to affect all patients who receive home health aide only services. (2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 2, start of care 12/4/12, evidenced a plan of care dated 12/4/12 through 2/1/13 with orders for home health aide services daily 7 days a week. The record evidenced the first aide service was provided on 12/4/12. The record failed to evidence a supervisory visit of the home health aide services until 1/31/13.</li> <li>An undated policy titled "Supervision of Staff" C-315 states, "2. If clients are receiving only home health aide services</li> </ol>	N000606	<p>After investigating this deficiency, we found that the problem revolved more around confusion of the actual due date and not the regulations for when they should be done. The nurses are all aware of the regulations for when the visits are due. However, some visits were being done late because the previous Supervisory Visit was done earlier than scheduled, throwing off the due date for the next scheduled visit. The Administrator now maintains a spreadsheet with the due dates for Supervisory Visits for every patient. This spreadsheet will be reviewed and updated weekly by the Administrator and/or Director of Nurses. The due dates will be entered on the nurses' work schedule by the Administrator and/or Director of Nurses to make sure the visits are done in a timely manner. (This is a web based scheduling program that can be accessed by all the nurses and managers and can be used as a communication tool for all staff.) If the visit is done earlier than the required due date, the RN doing that visit will report it to</p>	04/08/2013

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	<p>and there is no skilled service provided, a registered nurse will make a supervisory visit while the aide is providing care, at least once every 60 days, or per State / Agency guidelines."</p> <p>3. On 3/25/13 at 5 PM, during the clinical record review of record # 2, the assistant director of nursing indicated the supervisory visits were conducted at 60 day intervals with the reevaluation of the patient.</p>		<p>the Administrator in order to keep the schedule updated appropriately. In addition to this, all Supervisory Visits will be noted on the schedule after they are done to facilitate communication and to maintain the correct schedule for the next required Supervisory Visit. The schedule for all Supervisory visits will be monitored by the Administrator and/or Director of Nurses on a weekly (if not daily) basis. 10% of all charts will be audited every 30 days to ensure that the Supervisory Visits are done on time and prevent this deficiency from recurring again.</p>	