

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2012
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD STE 630 EVANSVILLE, IN 47715		
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G0000	<p>This was a home health federal recertification survey. This was a partial extended survey.</p> <p>Facility #: 012153</p> <p>Survey Dates: 12-10-12, 12-11-12, and 12-12-12</p> <p>Medicaid Vendor #: 200484160E</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 18, 2012</p>	G0000			

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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G0111	<p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS</p> <p>The patient has the right to confidentiality of the clinical records maintained by the HHA. Based on observation and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected in 1 (#1) of 1 observation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12-12-12 at 4:30 PM, observation noted an individual cleaning an office in the agency. The individual was observed to place a blue binder in a trash container. A label that included the patient's name (patient number 6) and the medical record number was observed on the outside of the binder. When asked, on 12-12-12 at 4:30 PM, the individual indicated the trash in the container would be placed in a dumpster in the parking lot of the home health agency. The agency is located in a complex with multiple offices and the parking lot serves everyone in the offices. The individual indicated he had not signed any confidentiality agreement with the agency. The individual stated, "My dad usually cleans this office. I am only here because he has to work 3rd shift 	G0111	Office cleaning personnel will review and sign privacy acknowledgement form prior to cleaning building again or before 1/11/13, whichever comes first. HIPAA and Confidentiality policies will be reviewed by all staff during weekly office meeting by 1/11/12 to ensure future compliance with medical record confidentiality, protection, and disclosure. Administrator will be responsible for correction and prevention and will conduct weekly HIPAA spot checks throughout the 1 st quarter 2013.	01/11/2013

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	<p>tonight."</p> <p>3. The administrator, employee A, indicated, he did not know confidential patient information was placed in a trash container available to the public. The administrator indicated there was not formal agreement between the agency and the cleaning individuals for the maintenance of confidential patient information.</p>			
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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and agency policy review, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures in 3 (#s 2, 3, & 4) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and all of the agency's 102 current patients.</p> <p>The findings include:</p> <p>1. The agency's 08-13-12 "Compliance With Policy and Regulation" policy number HH-LGA_004.3 states, "The Company, through the development of its policies and procedures, ensures compliance with the following: . . . Public health regulations relating to Infectious Disease."</p> <p>The agency's 4-19-10 "Hand Hygiene" policy number HH-ICS-005 states, "Personnel providing care in the home setting will regularly wash their hands, per the most recently CDC regulations and guidelines for hand hygiene in health</p>	G0121	<p>Director of Clinical Services or Clinical Designee will provide education to all direct caregivers, including employees D, E and F regarding proper standards for hand hygiene. This in-service will include company policy requirements as stated in policy HH-ICS-005 as well as VNAA Clinical guidelines for Hand Hygiene in the Health Care setting. Direct caregivers will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date for this education will be by January 11 th , 2013.</p> <p>Employee D, E and F will receive education regarding proper hand hygiene from Director of Clinical Services by January 11 th , 2013 and logged into the system of record. Director of Clinical Services will educate all Clinical Supervisors on policy HH-ICS-005 regarding hand hygiene as well as VNAA clinical guidelines for Hand Hygiene in the Health Care setting. Clinical Supervisors will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date</p>	01/11/2013

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	<p>care settings."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of</p>		<p>for this education will be by January 11 th , 2013. Furthermore to prevent this deficiency from recurring in the future, Director of Clinical Service or Clinical Supervisors will observe direct caregivers performing hand hygiene during the initial competency and during their annual competency evaluations. Clinical Supervisors will observe and monitor staff providing patient care for adherence to proper hand hygiene. This observation will take place during home supervisory visits when staff is present. The Clinical Supervisor will document the observation of staff on the Supervisory note, along with the effectiveness and any re-education provided.</p>		

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	<p>patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Employee E, a licensed practical nurse (LPN), was observed to provide care to patient number 3 during a home visit on 12-11-12 at 2:15 PM. The LPN was observed to prepare medications for administration to the patient via the patient's gastrointestinal tube (GI). The LPN was observed to pour the pills from the bottle into her un-gloved hand and place them into a container for 2 different medications.</p> <p>The LPN was then observed to wash her hands and don clean gloves. She changed the patient's tracheotomy tube which resulted in the patient expelling a moderate amount of mucous. The LPN cleaned the mucous from the patient's tracheotomy site with the towel already in place. The LPN removed the dirty gloves and donned clean gloves without cleansing her hands. The LPN then provided mouth care to the patient, removed her dirty gloves and donned clean gloves without cleansing her hands.</p>				

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	<p>The LPN then administered the medications that had been prepared earlier.</p> <p>4. Employee D, a registered nurse (RN), was observed to provide care to patient number 2 during a home visit on 12-11-12 at 2:40 PM. The RN was observed to prepare medication for administration to the patient via the patient's GI tube. The RN was observed to pour medications directly into her un-gloved hands and place them into a container for 2 different medications.</p> <p>After the medications had been prepared the patient began coughing. The RN was observed to don gloves without cleansing her hands and then suctioned the patient's tracheotomy tube.</p> <p>5. Employee F, an LPN, was observed to provide care to patient number 4 on 12-11-12 at 3:10 PM. The LPN was observed to don a glove on her left hand without cleansing her hands. The LPN then performed a blood glucose fingerstick check on the patient. The LPN failed to don a glove on her right hand during the procedure.</p> <p>After the blood glucose check had been completed, the LPN removed the glove from her left hand and failed to</p>						

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	<p>cleanse her hand. The LPN obtained some yogurt from the refrigerator and fed it to the patient.</p> <p>4. The above-stated observations were discussed with the supervising nurse, employee B, on 12-11-12 at 3:25 PM. The supervising nurse agreed the nurses had failed to follow the agency's infection control policies and the CDC's guidelines.</p>			

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G0131	<p>484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent. Based on administrative record review and interview, the agency failed to ensure the governing body had reviewed the agency's bylaws in 2 (2011 and 2012) of 2 years reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrator, employee A, indicated, on 12-12-12 at 3:40 PM it is the responsibility of the agency's professional advisory board to review the agency's bylaws. The administrator indicated the governing body members were also on the professional advisory board and the board meets on an annual basis. 2. The agency's 11-10-11 and 10-24-12 professional advisory board meeting minutes failed to evidence the board had reviewed the agency's bylaws. 3. The administrator, employee A, indicated, on 12-12-12 at 3:40 PM, the professional advisory board had reviewed the bylaws but that this action had not been included in the meeting minutes for 	G0131	Bylaws have been reviewed during scheduled governing board meeting on 12/31/2012. Bylaws have been added to the yearly Professional Advisory Board and Governing Board agendas to ensure minutes reflect review of bylaws. Administrator will be responsible for implementation.	12/31/2012	

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	2011 or 2012.			

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G0158	<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 clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered by the physician on the plan of care in 5 (#s 1, 2, 3, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 11-14-12 to 1-12-13. The plan of care identified the skilled nurse was to administer an intravenous medication one time per week. The plan of care states, "Using aseptic technique, access vein with 25 gu [gauge] butterfly. Flush vein with normal saline to check for patency."</p> <p>A skilled nurse visit note dated 11-27-12 failed to evidence the nurse had flushed the vein with normal saline prior to administering the medication. The note states, "IV initiated per [employee C] x [times] 1 attempt. Xyntha [name of</p>	G0158	<p>Director of Clinical Services or designee will educate skilled nurses who provide care for Clinical record #1, # 2 and #3 to ensure treatments had been provided as ordered per plan of care and write supplemental orders as changes occur in the plan of care to ensure all orders on the plan of care are current. The Director of Clinical Services will complete this by January 11 th , 2013. This education will be logged into the system of record. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of skilled notes to ensure that skilled nurses are providing current treatments to correlate with current physician order. Clinical record #9 indicated ordered staffing needs were not met per plan of care. Initially the recruiters call all available direct care to staff to check availability to meet the staffing requirement per plan of care. Then recruiters attempt to rearrange schedules to free up additional staff. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care</p>	01/11/2013			

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	<p>medication] administered."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN [skilled nurse] to put on AFO [ankle-foot orthotics] bilaterally to lower extremities 8 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 2, on 12-11-12 at 2:40 PM, employee D, the registered nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance won't pay for more."</p> <p>3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN to be apply DAFO [durable ankle-foot orthotic] to both legs and left wrist splint after [the patient's] bath and [the patient] is to wear them 4-6 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to</p>		<p>givers. In this situation missed shift forms were filled out per policy and the client's needs were met by the family. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. To ensure this deficiency does not happen again Administrative Officer will begin establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. The alternate agency will be contacted if the office cannot provide its own qualified staff. This process will begin on 1/11/13 and contracts will be in place by 1/25/13. We would elicit the assistance of a staffing agency or other contracted HHA agency once we cannot locate an available aide or nurse on staff and prior to missing the scheduled shift. The Administrative officer , Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and</p>		

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	<p>the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 3, on 12-11-12 at 2:15 PM, employee E, the licensed practical nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance will not pay for new ones."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 11-12-12 to 1-10-13 that states, "HHA [home health aide] 5-7 days per week, 42-70 hours per week for 9 weeks."</p> <p>A. The record evidenced only 3 aide visits the week of 11-12-12 and failed to evidence any aide visits had been provided the weeks of 11-18-12 and 11-25-12.</p> <p>B. The record included "Missed Visit/Shift Notification" notes, dated 11-13-12, 11-23-12, 11-28-12, and 12-5-12, that identify the reason for missed visit was due to "employee availability."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the aide visits had not been provided as ordered.</p>		<p>case-managers to assist with alternative staffing plans to meet the needs of the patient. Clinical record # 10 indicated SN visits had not been provided as ordered per plan of care. Upon referral we accept patients only when we have a reasonable expectation that the needs of the patient can be met. In the event the staff scheduled for this client submits an immediate letter of resignation after the admission occurred the recruiters will call all available direct care staff to check availability to meet the staffing requirement per plan of care. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care givers. There were no missed shifts filled out on this patient due to the fact that we were not staffing this case until school began. Prior to school starting the RN suddenly resigned leaving no available staff in their remote area to cover so we proceeded to discharge. This admission process was vetted through our compliance department prior to completion. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance.</p>		

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	<p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 7-16-12 to 9-13-12 that states, "SN 3-5 days per week, 26-40 hours per week for 9 weeks."</p> <p>A. The record failed to evidence any SN visits had been provided after the initial comprehensive assessment had been completed on 7-16-12.</p> <p>B. The record included a discharge order dated 8-20-12 that states, "Client to be discharged effective 8-20-12 per family request due to utilizing another company."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the SN visits had not been provided as ordered.</p> <p>6. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>		<p>The Administrative officer , Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet the needs of the patient.To prevent the above from reoccurring all direct care staff and internal employees will receive education to document and adhere to plan of care The Administrative officer and Director or designee will assume responsibility. Proof of education will be documented for new employees on orientation sheet under plan of care, internal employees during referral meeting and existing field staff by mailer. The effective date of this correction will be by January 11 th , 2013.</p>		

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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD STE 630 EVANSVILLE, IN 47715		
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G0164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's condition in 1 (#1) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a skilled nurse visit note, signed and dated by employee C, an RN, on 11-20-12, that states, "Left elbow slightly edematous. Small bruise on outer aspect of elbow. Child cries when elbow moved. Elbow warm to touch. [Parent] phone Dr [name] office for further orders." <p>The record failed to evidence the RN had informed the physician of the status of the patient's elbow.</p> <ol style="list-style-type: none"> 2. The supervising nurse, employee B, stated, on 12-12-12 at 1:00 PM, "We did not call the doctor because the mother had already called him." 	G0164	<p>Director of Clinical Services will educate Clinical Supervisors on policy # HH-CP-110 Observation, reporting and documentation of patient status and care or services provided and HH-CP-209 Emergencies in the home: Recognition and intervention and will be logged into the system of record. The effective date of this correction will be by January 11 th , 2013. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of field notes to ensure that field staff is reporting change in patient condition to internal clinicians to ensure physician has been contacted.</p>	01/11/2013	

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure the skilled nurse had provided treatments and visits as ordered by the physician on the plan of care in 4 (#s 1, 2, 3, and 10) of 10 records reviewed creating the potential to affect all of the agency's 21 current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 11-14-12 to 1-12-13. The plan of care identifies the skilled nurse was administer an intravenous medication one time per week. The plan of care states, "Using aseptic technique, access vein with 25 gu [gauge] butterfly. Flush vein with normal saline to check for patency."</p> <p>A skilled nurse visit note dated 11-27-12 failed to evidence the nurse had flushed the vein with normal saline prior to administering the medication. The note states, "IV initiated per [employee C] x [times] 1 attempt. Xyntha [name of medication] administered."</p>	G0170	<p>Director of Clinical Services or designee will educate skilled nurses who provide care for Clinical record #1, # 2 and #3 to ensure treatments had been provided as ordered per plan of care and write supplemental orders as changes occur in the plan of care to ensure all orders on the plan of care are current. The Director of Clinical Services will complete this by January 11 th , 2013. This education will be logged into the system of record. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of skilled notes to ensure that skilled nurses are providing current treatments to correlate with current physician order. Clinical record #9 indicated ordered staffing needs were not met per plan of care. Initially the recruiters call all available direct care to staff to check availability to meet the staffing requirement per plan of care. Then recruiters attempt to rearrange schedules to free up additional staff. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care givers. In this situation missed shift forms were filled out per policy and the client's needs were</p>	01/11/2013			

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	<p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN [skilled nurse] to put on AFO [ankle-foot orthotics] bilaterally to lower extremities 8 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 2, on 12-11-12 at 2:40 PM, employee D, the registered nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance won't pay for more."</p> <p>3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN to be apply DAFO [durable ankle-foot orthotic] to both legs and left wrist splint after [the patient's] bath and [the patient] is to wear them 4-6 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p>		<p>met by the family. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. To ensure this deficiency does not happen again Administrative Officer will begin establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. The alternate agency will be contacted if the office cannot provide its own qualified staff. This process will begin on 1/11/13 and contracts will be in place by 1/25/13. We would elicit the assistance of a staffing agency or other contracted HHA agency once we cannot locate an available aide or nurse on staff and prior to missing the scheduled shift. The Administrative officer, Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet the needs of the patient. Clinical record # 10 indicated SN visits had not been provided as ordered</p>				

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	<p>B. During a home visit to patient number 3, on 12-11-12 at 2:15 PM, employee E, the licensed practical nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance will not pay for new ones."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 7-16-12 to 9-13-12 that states, "SN 3-5 days per week, 26-40 hours per week for 9 weeks."</p> <p>A. The record failed to evidence any SN visits had been provided after the initial comprehensive assessment had been completed on 7-16-12.</p> <p>B. The record included a discharge order dated 8-20-12 that states, "Client to be discharged effective 8-20-12 per family request due to utilizing another company."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the SN visits had not been provided as ordered.</p> <p>5. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care</p>		<p>per plan of care. Upon referral we accept patients only when we have a reasonable expectation that the needs of the patient can be met. In the event the staff scheduled for this client submits an immediate letter of resignation after the admission occurred the recruiters will call all available direct care staff to check availability to meet the staffing requirement per plan of care. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care givers. There were no missed shifts filled out on this patient due to the fact that we were not staffing this case until school began. Prior to school starting the RN suddenly resigned leaving no available staff in their remote area to cover so we proceeded to discharge. This admission process was vetted through our compliance department prior to completion. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. The Administrative officer , Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of</p>				

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	(485) is the physician's order for home care services."		care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet the needs of the patient.		

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's condition in 1 (#1) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a skilled nurse visit note, signed and dated by employee C, an RN, on 11-20-12, that states, "Left elbow slightly edematous. Small bruise on outer aspect of elbow. Child cries when elbow moved. Elbow warm to touch. [Parent] phone Dr [name] office for further orders." <p>The record failed to evidence the RN had informed the physician of the status of the patient's elbow.</p> <ol style="list-style-type: none"> 2. The supervising nurse, employee B, stated, on 12-12-12 at 1:00 PM, "We did not call the doctor because the mother had already called him." 	G0176	<p>Director of Clinical Services will educate Clinical Supervisors on policy # HH-CP-110 Observation, reporting and documentation of patient status and care or services provided and HH-CP-209 Emergencies in the home: Recognition and intervention and will be logged into the system of record. The effective date of this correction will be by January 11 th , 2013. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of field notes to ensure that field staff is reporting change in patient condition to internal clinicians to ensure physician has been contacted.</p>	01/11/2013	

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G0237	<p>484.48(a) RETENTION OF RECORDS Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. Based on agency policy review and interview, the agency failed to ensure clinical record retention policies provided for the retention of clinical records in the event the agency ceases operation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's 5-13-11 "Cessation of Office Operations: Patient Care Contingency [sic] Plan" policy number HH-LC-010, the 5-13-11 "Document Retention" policy number HH-LC-009, the 3-3-11 "Medical Record: Content and Requirements" policy number HH-CL-002, and the 8-13-12 "Document Retention - Implementation Guidelines" policy number HH-LL-009.2 failed to provide for the retention of patients' clinical records in the event the agency would cease operations. 2. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the agency's policies did not provide for the 	G0237	Policy HH-LL-009.2, "Document Retention - Implementation Guidelines" was revised to reflect the requirement that records must be retained even in the event that the agency discontinues operations (see attached policy). This revision will be effective on 1/7/13.	01/07/2013	

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	retention of clinical records in the event the agency would cease operations. The supervising nurse was unable to provide any further policies to meet this requirement.			

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G0239	<p>484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use. Based on observation and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected in 1 (#1) of 1 observation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12-12-12 at 4:30 PM, observation noted an individual cleaning an office in the agency. The individual was observed to place a blue binder in a trash container. A label that included the patient's name (patient number 6) and the medical record number was observed on the outside of the binder. When asked, on 12-12-12 at 4:30 PM, the individual indicated the trash in the container would be placed in a dumpster in the parking lot of the home health agency. The agency is located in a complex with multiple offices and the parking lot serves everyone in the offices. The individual indicated he had not signed any confidentiality agreement with the agency. The individual stated, "My dad usually cleans this office. I am only here because he has to work 3rd shift tonight." 	G0239	Office cleaning personnel will review and sign privacy acknowledgement form prior to cleaning building again or before 1/11/13, whichever comes first. HIPAA and Confidentiality policies will be reviewed by all staff during weekly office meeting by 1/11/12 to ensure future compliance with medical record confidentiality, protection, and disclosure. Administrator will be responsible for correction and prevention and will conduct weekly HIPAA spot checks throughout the 1 st quarter 2013.	01/11/2013			

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	3. The administrator, employee A, indicated, he did not know confidential patient information was placed in a trash container available to the public. The administrator indicated there was not formal agreement between the agency and the cleaning individuals for the maintenance of confidential patient information.			

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G0332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record and agency policy review and interview, the agency failed to ensure initial assessments had been completed within 48 hours of the referral date in 4 (#s 6, 8, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's future admissions.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a "Supplementary Physician's Order" dated 5-6-11 that states, "Order to assess for appropriateness and admit to Maxim Healthcare Services if appropriate for home health aide services for Medicaid PA."</p> <p>A. The record included a plan of care for the certification period 5-10-11 to 7-8-11 that evidenced a verbal start of care order signed and dated by employee L, a registered nurse, on 5-6-11.</p> <p>B. The record failed to evidence the initial assessment had been completed within 48 hours. The record evidenced the initial assessment had been completed</p>	G0332	Director of Clinical Services and Administrative officer will be responsible for reviewing 100% of referral forms to ensure initial assessments have been scheduled within 48 hours of acceptance of referral. In the event the assessment cannot be performed within that time frame a second verbal start of care will be obtained and notation made on the referral or quick intake form. The Director of Clinical Services will educate all Clinical Supervisors on this standard by January 11 th , 2013.	01/11/2013			

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	<p>on 5-9-11.</p> <p>2. Clinical record number 8 included a "Supplementary Physician's Order" dated 7-20-12 that states, "Order to assess for appropriateness and admit to Maxim Healthcare Services if appropriate for home health aide services."</p> <p>The record failed to evidence the initial assessment had been completed within 48 hours. The record evidenced the initial assessment had been completed on 7-24-12.</p> <p>3. Clinical record number 9 included a "Supplementary Physician's Order" dated 11-19-10 that states, "Order to assess for appropriateness and admit to Maxim Healthcare Services if appropriate for home health aide service."</p> <p>The record failed to evidence the initial assessment had been completed within 48 hours. The record evidenced the initial assessment had been completed on 11-23-10.</p> <p>4. Clinical record number 10 included a "Supplementary Physician's Order" dated 7-13-12 that states, "Order to assess for appropriateness and admit to Maxim Healthcare Services if appropriate for skilled nursing care."</p>						

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	<p>A. The record included a plan of care for the certification period 7-16-12 to 9-13-12 with a verbal start of care date of 7-13-12.</p> <p>B. The record failed to evidence an initial assessment had been completed within 48 hours. The record evidenced the initial assessment had been completed on 7-16-12.</p> <p>5. The agency's 1-9-12 "Referrals" policy number HH-CL-003.2 states, "All referrals must be confirmed with the ordering physician by the DOCS [director of clinical services] or clinical designee. The confirmation as recorded on the PRIF [referral form] will include at a minimum: Verbal start of care date (VSOC) as appropriate, Orders for services, Signature and title of the employee receiving the confirmation."</p> <p>The agency's 3-18-11 "Acceptance and/or Admission of Patients" policy number HH-CL-006 states, "An initial comprehensive assessment will be completed for every accepted referral within 48 hours of the verbal start of care date, hospital discharge date or on the date as ordered by the physician. Delays in the initial comprehensive assessment will be documented on the Patient</p>				

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	<p>Referral and Intake Form (PRIF) and as required, the physician will be notified of any delay in the start of care."</p> <p>6. The agency's supervising nurse, employee B, stated, on 12-12-12 at 12:35 PM, "Once a patient is accepted we assign the case to a clinical supervisor, call the family, and set up the initial assessment within 48 hours. We call the physician and obtain a verbal start of care order. We do the initial comprehensive assessment at one time. The treatment orders are obtained after the nurse does the initial comprehensive assessment."</p>			

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G0334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure comprehensive assessments had been completed after the start of care in 2 (#s 6 and 7)) of 10 records reviewed creating the potential to affect all of the agency's future admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 included a plan of care for the certification period 5-10-11 to 7-8-11 that identified the start of care date as 5-10-11. The record evidenced the initial comprehensive assessment had been completed on 5-9-11. 2. Clinical record number 7 included a plan of care for the certification period 11-19-12 to 1-17-13 that identified the start of care date as 5-23-12. The record evidenced the initial comprehensive assessment had been completed on 5-22-12. 3. The administrator, employee AA, 	G0334	See attached appeal. Initial Comprehensive assessments will be completed on or after the start of care date, but no later than 5 days after the start of care. To ensure this the Director of Clinical Services or designee will scheduled the comprehensive assessments to be completed on the start of care date which is our policies first billable visit . Director of Clinical Services has educated all Clinical Supervisors on 1/10/13 to this change in process. To ensure the deficieny will not recur in the future the Director of Clinical Service audits 100% of new admission clinical records during the Quarterly review process and will be logged into the electronic audit tool.	01/11/2013	

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N0000	<p>indicated, on 12-12-12 at 12:35 PM, the initial comprehensive assessments had been completed prior to the start of care date.</p> <p>This was a home health State re-licensure survey.</p> <p>Facility #: 012153</p> <p>Survey Dates: 12-10-12, 12-11-12, and 12-12-12</p> <p>Medicaid Vendor #: 200484160E</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>December 18, 2012</p>	N0000		

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N0442	<p>410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on administrative record review and interview, the agency failed to ensure the governing body had reviewed the agency's bylaws in 2 (2011 and 2012) of 2 years reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency's administrator, employee A, indicated, on 12-12-12 at 3:40 PM it is the responsibility of the agency's professional advisory board to review the agency's bylaws. The administrator indicated the governing body members were also on the professional advisory board and the board meets on an annual basis. The agency's 11-10-11 and 10-24-12 professional advisory board meeting minutes failed to evidence the board had 	N0442	Bylaws have been reviewed during scheduled governing board meeting on 12/31/2012. Bylaws have been added to the yearly Professional Advisory Board and Governing Board agendas to ensure minutes reflect review of bylaws. Administrator will be responsible for implementation.	12/31/2012	

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	<p>reviewed the agency's bylaws.</p> <p>3. The administrator, employee A, indicated, on 12-12-12 at 3:40 PM, the professional advisory board had reviewed the bylaws but that this action had not been included in the meeting minutes for 2011 or 2012.</p>			

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and agency policy review, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures in 3 (#s 2, 3, & 4) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and all of the agency's 102 current patients.</p> <p>The findings include:</p> <p>1. The agency's 08-13-12 "Compliance With Policy and Regulation" policy number HH-LGA_004.3 states, "The Company, through the development of its policies and procedures, ensures compliance with the following: . . . Public health regulations relating to Infectious Disease."</p> <p>The agency's 4-19-10 "Hand Hygiene" policy number HH-ICS-005 states, "Personnel providing care in the home setting will regularly wash their hands, per the most recently CDC regulations</p>	N0470	<p>Director of Clinical Services or Clinical Designee will provide education to all direct caregivers, including employees D, E and F regarding proper standards for hand hygiene. This in-service will include company policy requirements as stated in policy HH-ICS-005 as well as VNAA Clinical guidelines for Hand Hygiene in the Health Care setting. Direct caregivers will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date for this education will be by January 11 th , 2013.</p> <p>Employee D, E and F will receive education regarding proper hand hygiene from Director of Clinical Services by January 11 th , 2013 and logged into the system of record. Director of Clinical Services will educate all Clinical Supervisors on policy HH-ICS-005 regarding hand hygiene as well as VNAA clinical guidelines for Hand Hygiene in the Health Care setting. Clinical Supervisors will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene</p>	01/11/2013			

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	<p>and guidelines for hand hygiene in health care settings."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile</p>		<p>requirements. The completion date for this education will be by January 11 th , 2013. Furthermore to prevent this deficiency from recurring in the future, Director of Clinical Services or Clinical Supervisors will observe all direct caregivers performing hand hygiene during the initial competency and during their annual competency evaluations. Clinical Supervisors will observe and monitor staff providing patient care for adherence to proper hand hygiene. This observation will take place during home supervisory visits when staff is present. The Clinical Supervisor will document the observation of staff on the Supervisory note, along with the effectiveness and any re-education provided.</p>	

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	<p>devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Employee E, a licensed practical nurse (LPN), was observed to provide care to patient number 3 during a home visit on 12-11-12 at 2:15 PM. The LPN was observed to prepare medications for administration to the patient via the patient's gastrointestinal tube (GI). The LPN was observed to pour the pills from the bottle into her un-gloved hand and place them into a container for 2 different medications.</p> <p>The LPN was then observed to wash her hands and don clean gloves. She changed the patient's tracheotomy tube which resulted in the patient expelling a moderate amount of mucous. The LPN cleaned the mucous from the patient's tracheotomy site with the towel already in place. The LPN removed the dirty gloves and donned clean gloves without cleansing her hands. The LPN then provided mouth care to the patient, removed her dirty gloves and donned</p>						

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	<p>clean gloves without cleansing her hands. The LPN then administered the medications that had been prepared earlier.</p> <p>4. Employee D, a registered nurse (RN), was observed to provide care to patient number 2 during a home visit on 12-11-12 at 2:40 PM. The RN was observed to prepare medication for administration to the patient via the patient's GI tube. The RN was observed to pour medications directly into her un-gloved hands and place them into a container for 2 different medications.</p> <p>After the medications had been prepared the patient began coughing. The RN was observed to don gloves without cleansing her hands and then suctioned the patient's tracheotomy tube.</p> <p>5. Employee F, an LPN, was observed to provide care to patient number 4 on 12-11-12 at 3:10 PM. The LPN was observed to don a glove on her left hand without cleansing her hands. The LPN then performed a blood glucose fingerstick check on the patient. The LPN failed to don a glove on her right hand during the procedure.</p> <p>After the blood glucose check had been completed, the LPN removed the</p>				

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	<p>glove from her left hand and failed to cleanse her hand. The LPN obtained some yogurt from the refrigerator and fed it to the patient.</p> <p>4. The above-stated observations were discussed with the supervising nurse, employee B, on 12-11-12 at 3:25 PM. The supervising nurse agreed the nurses had failed to follow the agency's infection control policies and the CDC's guidelines.</p>			

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N0488	<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 the following circumstances: (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. (2) The patient refuses the home health agency's services. (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 (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 policy review and interview, the agency failed to ensure a policy requiring a 5 day notice of discharge had been developed and implemented creating the potential to affect all of the agency's 102 current patients.</p>	N0488	Policy HH-CL-021.3, "Discharge" was revised to reflect the discharge requirements set forth in 410 IAC 17-12-2(i) and (j). The revision will be effective 1/7/13.	01/07/2013	

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's 8-13-12 "Discharge of Patients" policy number HH-CL-021.3 failed to evidence a notice of discharge to the patient of at least five (5) calendar days. The policy also failed to evidence the circumstances under which the 5 day notice would not apply. 2. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the agency's discharge policy did not include the 5 day notice requirement along with the exceptions. 				

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N0508	<p>410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (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: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p> <p>Based on observation and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected in 1 (#1) of 1 observation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12-12-12 at 4:30 PM, observation noted an individual cleaning an office in the agency. The individual was observed to place a blue binder in a trash container. A label that included the patient's name (patient number 6) and the medical record number was observed on the outside of the binder. When asked, on 12-12-12 at 4:30 PM, the individual indicated the trash in the container would be placed in a dumpster in the parking lot of the home health agency. The agency is located in a 	N0508	Office cleaning personnel will review and sign privacy acknowledgement form prior to cleaning building again or before 1/11/13, whichever comes first. HIPAA and Confidentiality policies will be reviewed by all staff during weekly office meeting by 1/11/12 to ensure future compliance with medical record confidentiality, protection, and disclosure. Administrator will be responsible for correction and prevention and will conduct weekly HIPAA spot checks throughout the 1 st quarter 2013.	01/11/2013	

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	<p>complex with multiple offices and the parking lot serves everyone in the offices. The individual indicated he had not signed any confidentiality agreement with the agency. The individual stated, "My dad usually cleans this office. I am only here because he has to work 3rd shift tonight."</p> <p>3. The administrator, employee A, indicated, he did not know confidential patient information was placed in a trash container available to the public. The administrator indicated there was not formal agreement between the agency and the cleaning individuals for the maintenance of confidential patient information.</p>				

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered by the physician on the plan of care in 5 (#s 1, 2, 3, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 11-14-12 to 1-12-13. The plan of care identified the skilled nurse was to administer an intravenous medication one time per week. The plan of care states, "Using aseptic technique, access vein with 25 gu [gauge] butterfly. Flush vein with normal saline to check for patency."</p> <p>A skilled nurse visit note dated 11-27-12 failed to evidence the nurse had flushed the vein with normal saline prior to administering the medication. The note states, "IV initiated per [employee C] x [times] 1 attempt. Xyntha [name of</p>	N0522	<p>Director of Clinical Services or designee will educate skilled nurses who provide care for Clinical record #1, # 2 and #3 to ensure treatments had been provided as ordered per plan of care and write supplemental orders as changes occur in the plan of care to ensure all orders on the plan of care are current. The Director of Clinical Services will complete this by January 11 th , 2013. This education will be logged into the system of record. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of skilled notes to ensure that skilled nurses are providing current treatments to correlate with current physician order. Clinical record #9 indicated ordered staffing needs were not met per plan of care. Initially the recruiters call all available direct care to staff to check availability to meet the staffing requirement per plan of care. Then recruiters attempt to rearrange schedules to free up additional staff. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care</p>	01/11/2013			

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	<p>medication] administered."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN [skilled nurse] to put on AFO [ankle-foot orthotics] bilaterally to lower extremities 8 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 2, on 12-11-12 at 2:40 PM, employee D, the registered nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance won't pay for more."</p> <p>3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN to be apply DAFO [durable ankle-foot orthotic] to both legs and left wrist splint after [the patient's] bath and [the patient] is to wear them 4-6 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to</p>		<p>givers. In this situation missed shift forms were filled out per policy and the client's needs were met by the family. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. To ensure this deficiency does not occur again Administrative Officer will begin establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. The alternate agency will be contacted if the office cannot provide its own qualified staff. This process will begin on 1/11/13 and contracts will be in place by 1/25/13. We would elicit the assistance of a staffing agency or other contracted HHA agency once we cannot locate an available aide or nurse on staff and prior to missing the scheduled shift. The Administrative officer, Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet</p>		

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	<p>the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 3, on 12-11-12 at 2:15 PM, employee E, the licensed practical nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance will not pay for new ones."</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 11-12-12 to 1-10-13 that states, "HHA [home health aide] 5-7 days per week, 42-70 hours per week for 9 weeks."</p> <p>A. The record evidenced only 3 aide visits the week of 11-12-12 and failed to evidence any aide visits had been provided the weeks of 11-18-12 and 11-25-12.</p> <p>B. The record included "Missed Visit/Shift Notification" notes, dated 11-13-12, 11-23-12, 11-28-12, and 12-5-12, that identify the reason for missed visit was due to "employee availability."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the aide visits had not been provided as ordered.</p>		<p>the needs of the patient. Clinical record # 10 indicated SN visits had not been provided as ordered per plan of care. Upon referral we accept patients only when we have a reasonable expectation that the needs of the patient can be met. In the event the staff scheduled for this client submits an immediate letter of resignation after the admission occurred the recruiters will call all available direct care staff to check availability to meet the staffing requirement per plan of care. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care givers. There were no missed shifts filled out on this patient due to the fact that we were not staffing this case until school began. Prior to school starting the RN suddenly resigned leaving no available staff in their remote area to cover so we proceeded to discharge. This admission process was vetted through our compliance department prior to completion. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. The Administrative officer , Director of Clinical Services or</p>		

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	<p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 7-16-12 to 9-13-12 that states, "SN 3-5 days per week, 26-40 hours per week for 9 weeks."</p> <p>A. The record failed to evidence any SN visits had been provided after the initial comprehensive assessment had been completed on 7-16-12.</p> <p>B. The record included a discharge order dated 8-20-12 that states, "Client to be discharged effective 8-20-12 per family request due to utilizing another company."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the SN visits had not been provided as ordered.</p> <p>6. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."</p>		<p>designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet the needs of the patient. To prevent the above from reoccurring all direct care staff and internal employees will receive education to document and adhere to plan of care. The Administrative officer and Director or designee will assume responsibility. Proof of education will be documented for new employees on orientation sheet under plan of care, internal employees during referral meeting and existing field staff by mailer. The effective date of this correction will be by January 11 th , 2013.</p>				

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N0527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's condition in 1 (#1) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a skilled nurse visit note, signed and dated by employee C, an RN, on 11-20-12, that states, "Left elbow slightly edematous. Small bruise on outer aspect of elbow. Child cries when elbow moved. Elbow warm to touch. [Parent] phone Dr [name] office for further orders." <p>The record failed to evidence the RN had informed the physician of the status of the patient's elbow.</p> <ol style="list-style-type: none"> 2. The supervising nurse, employee B, stated, on 12-12-12 at 1:00 PM, "We did not call the doctor because the mother had already called him." 	N0527	<p>Director of Clinical Services will educate Clinical Supervisors on policy # HH-CP-110 Observation, reporting and documentation of patient status and care or services provided and HH-CP-209 Emergencies in the home: Recognition and intervention and will be logged into the system of record. The effective date of this correction will be by January 11 th , 2013. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of field notes to ensure that field staff is reporting change in patient condition to internal clinicians to ensure physician has been contacted.</p>	01/11/2013	

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse and licensed practical nurse had provided treatments and visits as ordered by the physician on the plan of care in 4 (#s 1, 2, 3, and 10) of 10 records reviewed creating the potential to affect all of the agency's 21 current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 11-14-12 to 1-12-13. The plan of care identifies the skilled nurse was administer an intravenous medication one time per week. The plan of care states, "Using aseptic technique, access vein with 25 gu [gauge] butterfly. Flush vein with normal saline to check for patency."</p> <p>A skilled nurse visit note dated 11-27-12 failed to evidence the nurse had flushed the vein with normal saline prior to administering the medication. The note</p>	N0537	<p>Director of Clinical Services or designee will educate skilled nurses who provide care for Clinical record #1, # 2 and #3 to ensure treatments had been provided as ordered per plan of care and write supplemental orders as changes occur in the plan of care to ensure all orders on the plan of care are current. The Director of Clinical Services will complete this by January 11 th , 2013. This education will be logged into the system of record. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of skilled notes to ensure that skilled nurses are providing current treatments to correlate with current physician order. Clinical record #9 indicated ordered staffing needs were not met per plan of care. Initially the recruiters call all available direct care to staff to check availability to meet the staffing requirement per plan of care. Then recruiters attempt to rearrange schedules to free up additional staff. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care</p>	01/11/2013			

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	<p>states, "IV initiated per [employee C] x [times] 1 attempt. Xyntha [name of medication] administered."</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN [skilled nurse] to put on AFO [ankle-feet orthotics] bilaterally to lower extremities 8 hours daily."</p> <p>A. Daily skilled nurse visit notes dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 2, on 12-11-12 at 2:40 PM, employee D, the registered nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance won't pay for more."</p> <p>3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-8-12 to 12-6-12 that states, "SN to be apply DAFO [durable ankle-foot orthotic] to both legs and left wrist splint after [the patient's] bath and [the patient] is to wear them 4-6 hours daily."</p> <p>A. Daily skilled nurse visit notes</p>		<p>givers. In this situation missed shift forms were filled out per policy and the client's needs were met by the family. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. To ensure this deficiency does not occur again Administrative Officer will begin establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. The alternate agency will be contacted if the office cannot provide its own qualified staff. This process will begin on 1/11/13 and contracts will be in place by 1/25/13. We would elicit the assistance of a staffing agency or other contracted HHA agency once we cannot locate an available aide or nurse on staff and prior to missing the scheduled shift. The Administrative officer, Director of Clinical Services or designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet</p>				

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	<p>dated 10-8-12 through 12-1-12 failed to evidence the braces had been applied to the patient's lower extremities as ordered.</p> <p>B. During a home visit to patient number 3, on 12-11-12 at 2:15 PM, employee E, the licensed practical nurse caring for the patient, stated, "We do not use them anymore. [The patient] outgrew them and insurance will not pay for new ones."</p> <p>4. Clinical record number 10 included a plan of care established by the physician for the certification period 7-16-12 to 9-13-12 that states, "SN 3-5 days per week, 26-40 hours per week for 9 weeks."</p> <p>A. The record failed to evidence any SN visits had been provided after the initial comprehensive assessment had been completed on 7-16-12.</p> <p>B. The record included a discharge order dated 8-20-12 that states, "Client to be discharged effective 8-20-12 per family request due to utilizing another company."</p> <p>C. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the SN visits had not been provided as ordered.</p>		<p>the needs of the patient. Clinical record # 10 indicated SN visits had not been provided as ordered per plan of care. Upon referral we accept patients only when we have a reasonable expectation that the needs of the patient can be met. In the event the staff scheduled for this client submits an immediate letter of resignation after the admission occurred the recruiters will call all available direct care staff to check availability to meet the staffing requirement per plan of care. If no staff available missed shift forms are filled out per policy and alternate forms of care are discussed with their primary care givers. There were no missed shifts filled out on this patient due to the fact that we were not staffing this case until school began. Prior to school starting the RN suddenly resigned leaving no available staff in their remote area to cover so we proceeded to discharge. This admission process was vetted through our compliance department prior to completion. If it is identified that staffing availability will not be intermittent but long-term then we will refer to our discharge policy because we have met one of the criteria for discharge that states available personnel are inadequate for the continuing needs of the client and notify our legal representative for guidance. The Administrative officer , Director of Clinical Services or</p>		

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	5. The agency's 6-14-12 "Home Health Certification and Plan(s) of Care" policy number HH-CL-007.4 states, "The Home Health Certification and Plan of Care (485) is the physician's order for home care services."		designee will assume responsibility to insure adherence to staffing per plan of care, discharge policy and contacting physicians and case-managers to assist with alternative staffing plans to meet the needs of the patient. To prevent the above from reoccurring all direct care staff and internal employees will receive education to document and adhere to plan of care. The Administrative officer and Director or designee will assume responsibility. Proof of education will be documented for new employees on orientation sheet under plan of care, internal employees during referral meeting and existing field staff by mailer. The effective date of this correction will be by January 11 th , 2013.		

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N0546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had informed the physician of a change in the patient's condition in 1 (#1) of 10 records reviewed creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note, signed and dated by employee C, an RN, on 11-20-12, that states, "Left elbow slightly edematous. Small bruise on outer aspect of elbow. Child cries when elbow moved. Elbow warm to touch. [Parent] phone Dr [name] office for further orders."</p> <p>The record failed to evidence the RN had informed the physician of the status of the patient's elbow.</p>	N0546	<p>Director of Clinical Services will educate Clinical Supervisors on policy # HH-CP-110 Observation, reporting and documentation of patient status and care or services provided and HH-CP-209 Emergencies in the home: Recognition and intervention and will be logged into the system of record. The effective date of this correction will be by January 11 th , 2013. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of field notes to ensure that field staff is reporting change in patient condition to internal clinicians to ensure physician has been contacted.</p>	01/11/2013			

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	2. The supervising nurse, employee B, stated, on 12-12-12 at 1:00 PM, "We did not call the doctor because the mother had already called him."			

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N0559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on clinical record review and interview, the agency failed to ensure the licensed practical nurse (LPN) had consulted with the supervising registered nurse prior to contacting the physician in 1 (#2) of 5 records reviewed of patients that received skilled nursing services creating the potential to affect all of the agency's 21 current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a skilled nurse (SN) visit note, signed and dated by employee E, a licensed practical nurse (LPN), on 11-28-12. The note states, "Right eye crusty yellow discharge . . . left eye yellow discharge from inner corner of eye. Will call MD this AM for orders . . . Dr's office returned call, will give [name of doctor] the message but needs to be seen its been over year . . . Dr. [name] office returned call order received."</p>	N0559	Director of Clinical Services will educate Clinical Supervisors and LPN's that all LPN's must consult with the supervising RN prior to contacting a physician and log that conversation in the system of record. This education will be logged into the system of record by January 11 th , 2013. To ensure deficiency will not recur in the future the Director of Clinical Services or designee will complete 100% weekly review of LPN notes to ensure that they have contacted supervising RN prior to contacting the physician.	01/11/2013			

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	<p>The record failed to evidence the LPN had consulted with the supervising RN prior to contacting the physician and informing him of the problem with the patient's eyes.</p> <p>2. The supervising nurse, employee indicated, on 12-12-12 at 2:30 PM, the record did not evidence documentation the LPN had consulted with the supervising RN prior to contacting the physician.</p>			

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides had completed a competency evaluation that addressed all of the required subject areas in 4 (files G, H, I, and J) of 4 home health aide files reviewed creating the potential to affect all of the agency's 81 current patients that received home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file G evidenced the individual had been hired on 1-5-11 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered to employee G on 1-5-11 and 1-7-11. The file failed to evidence the competency evaluation had addressed medication assistance as required by 410 IAC 17-14-1 (h)(13).</p>	N0596	See attached appeal. The Home Health Aide competency evaluations will show evidence that medication assistance is addressed per regulation. The Director of Clinical Services or designee will reference medication assistance aide competency protocol (see attached) when performing 100% of new hire and annual competency evaluations. The Director of Clinical Services educated Clinical Supervisors on new process by 1/11/13 and will be logged into the system of record. To ensure this deficiency will not recur in the future the Director of Clinical Services or her designee will review 100% of new hire and annual competency forms prior to filing in HR record.	01/11/2013			

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	<p>2. Personnel file H evidenced the individual had been hired on 2-8-12 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered to employee H on 2-8-12 and 2-14-12. The file failed to evidence the competency evaluation had addressed medication assistance as required by 410 IAC 17-14-1 (h)(13).</p> <p>3. Personnel file I evidenced the individual had been hired on 10-30-12 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered to employee I on 11-13-12. The file failed to evidence the competency evaluation had addressed medication assistance as required by 410 IAC 17-14-1 (h)(13).</p> <p>4. Personnel file J evidenced the individual had been hired on 2-29-12 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered to employee J on 3-20-12. The file failed to evidence the competency evaluation had addressed medication assistance as required by 410 IAC 17-14-1 (h)(13).</p> <p>5. The supervising nurse, employee B,</p>			

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	<p>stated, on 12-12-12 at 2:25 PM, "Our competency evaluation does not address medication assistance. Our aides do not administer medications but they do sometimes assist with medications."</p> <p>6. The agency's 8-29-12 "Competency Evaluation" policy number HH-HR-008.5 states, "An initial competency evaluation shall be completed prior to providing independent patient care."</p>			

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N0612	<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 agency policy review and interview, the agency failed to ensure clinical record retention policies provided for the retention of clinical records in the event the agency ceases operation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's 5-13-11 "Cessation of Office Operations: Patient Care Contingency [sic] Plan" policy number HH-LC-010, the 5-13-11 "Document Retention" policy number HH-LC-009, the 3-3-11 "Medical Record: Content and Requirements" policy number HH-CL-002, and the 8-13-12 "Document Retention - Implementation Guidelines" policy number HH-LL-009.2 failed to provide for the retention of patients' clinical records in the event the agency would cease operations. 2. The supervising nurse, employee B, indicated, on 12-12-12 at 3:55 PM, the agency's policies did not provide for the 	N0612	<p>Policy HH-LL-009.2, "Document Retention - Implementation Guidelines" was revised to reflect the requirement that records must be retained even in the event that the agency discontinues operations (see attached policy). This revision will be effective by 1/7/13.</p>	01/07/2013	

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	retention of clinical records in the event the agency would cease operations. The supervising nurse was unable to provide any further policies to meet this requirement.			

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N0614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on observation and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected in 1 (#1) of 1 observation creating the potential to affect all of the agency's 102 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On 12-12-12 at 4:30 PM, observation noted an individual cleaning an office in the agency. The individual was observed to place a blue binder in a trash container. A label that included the patient's name (patient number 6) and the medical record number was observed on the outside of the binder. 2. When asked, on 12-12-12 at 4:30 PM, 	N0614	Office cleaning personnel will review and sign privacy acknowledgement form prior to cleaning building again or before 1/11/13, whichever comes first. HIPAA and Confidentiality policies will be reviewed by all staff during weekly office meeting by 1/11/12 to ensure future compliance with medical record confidentiality, protection, and disclosure. Administrator will be responsible for correction and prevention and will conduct weekly HIPAA spot checks throughout the 1st quarter 2013.	01/11/2013	

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	<p>the individual indicated the trash in the container would be placed in a dumpster in the parking lot of the home health agency. The agency is located in a complex with multiple offices and the parking lot serves everyone in the offices. The individual indicated he had not signed any confidentiality agreement with the agency. The individual stated, "My dad usually cleans this office. I am only here because he has to work 3rd shift tonight."</p> <p>3. The administrator, employee A, indicated, he did not know confidential patient information was placed in a trash container available to the public. The administrator indicated there was not formal agreement between the agency and the cleaning individuals for the maintenance of confidential patient information.</p>				