STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIGHT AT HOME, INC	1135 BROADWAY STREET ANDERSON, IN 46012

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G 0000 Bldg. 00	This was a state and federal initial licensure survey. Facility #: 014255 Survey Dates: January 4, 5, 8, 9; 2018 Skilled unduplicated census for provisional license period = 11 patients Sample Selection: Home visits with record review = 4 Record review without home visits = 7 Total Records reviewed = 11	G 0000		
G 0102 Bldg. 00	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. Based on record review, interview, and policy review the agency failed to obtain proper consent for treatment before the initiation of care for 1 out of 11 records	G 0102	o:p> /span> o:p> 1. On **1-15-18**, clarification order was written and faxed to patient #8's physician (copy	01/17/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	reviewed (# 8). Findings include: 1. The clinical record of patient #8 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence signed consents prior to the initiation of care. A. The agency document titled "Comprehensive Adult Nursing Assessment," was completed and dated 9/22/17. B. The agency consent document titled " Emergency Plan," was completed and dated 9/23/17. C. The agency consent document titled " Right At Home, Inc.," stated " Home care services have been initiated on 9/23/17." This document was signed by the patient and employee B on 9/23/17. D. The agency consents document titled " Admission Service Agreement Home Health," was initialed and signed by the patient and that employee B on 9/23/17. E. During an interview on 1/5/18 at		included). 2. On **1-16-18** the clarification order was signed by patient #8's physician. 3. On **1-17-18**, patient #8 was notified of the clerical error, a home visit was made and patient #8 was given a copy of the signed physician clarification order. Patient #8 verbalized understanding that the consent was reviewed and signed on 9-22-17 along with the comprehensive assessment. Patient #8 co-signed physician order, retained a copy, and original was place on patient #8's chart. **The Agency will prevent the deficiency from recurring by:** The Administrator, Director of Nursing, Quality Improvement Coordinator or designee will complete 100% audit of all admit. These audits will be completed within 48 hours of submission of admission documents. The documentation audit is to ensure dates of admission and consent which includes the patients' rights correlate and date errors do not recur. Audits will be ongoing to ensure compliance and consistency of all medical records. All registered nurses will be oriented upon hire regarding	

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	2:15 PM, the assistant director of nursing stated that the start of care date is the date that consents are signed.		assessment date and consent date correlating. The Administrator, Director of Nursing, Quality Improvement Coordinator or designee **are responsible for correcting the deficiency and preventing it from recurring.** **The deficiency will be corrected by (date):** 1-17-18	
G 0121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on record review, observation, and interview the agency failed to ensure that agency staff followed infection control policies for 1 of 4 home visits (#4). Findings include: 1. The clinical record of patient #4 was	G 0121	o:p=""> G121: What is the agency's plan to ensure that this deficiency will not occur with the entire clinical staff? **The agency has corrected this deficiency:** On 1.11.18, All clinical staff completed in-services consisting of Hand Hygiene and Infection Control videos, as well as, in service tests. The Director of	01/11/2018

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	reviewed on 1/4/18 and indicated a start of care date of 11/2/17. The record contained a plan of care dated 11/2/17-12/31/17. A. During observation on 1/9/18 at 10:30 AM employee D, HHA (Home Health Aide) was observed providing personal care. The HHA assisted the patient in the shower. With gloved hands, the HHA rubbed soap all over the washcloth with hands. The HHA then washed the patient's back. While patient finished the shower alone, the HHA stood outside of the shower. HHA then dried patients' back and assisted with applying robe. HHA then assisted with applying brief and pushed patient to room using rollator walker. The HHA failed to remove gloves, complete hand hygiene, and apply new gloves in between patient tasks. B. At the end of care the HHA cleaned work station, picked up dirty linen and removed gloves. The HHA failed to complete hand hygiene after care was completed and gloves were removed. 2. During an interview on 1/9/18 at 2:22 PM, the director of nursing stated that glove changes should occur anytime gloves are soiled or in between tasks.		Nursing educated all clinical staff on policy 5010-Standard Precautions, Policy 5011 Hand Hygiene and N131 Glove Technique. All staff was competency checked on Hand Hygiene and Glove Technique. 100% of all clinical staff passed in-service tests and proper hand hygiene and glove technique. **The agency will prevent the deficiency from recurring by:** Upon hire and annually, all clinical staff will complete in-services consisting of Hand Hygiene, Standard Precautions, and Glove Technique. All clinical staff will be competency checked upon hire, at 90 day evaluation, annually and as needed. On 1.10.18 and Ongoing: All clinical staff will be educated on Hand Hygiene, Standard Precautions, Glove Technique, PPE Usage, and Infection Control Policies with videos, return demonstration, upon hire, at 90 day evaluation, annually and as needed. The Administrator and Director of Nursing **are responsible for ensuring that this deficiency does not recur.** **The deficiency was corrected by 1.11.18**	

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	3. During an interview on 1/9/18 at 2:21 PM, the director of nursing stated that hand hygiene should be completed before care, during care, anytime gloves are changed, when gloves are soiled and after care. 4. The agency policy dated 7/24/17, titled "STANDARD PRECAUTION," Reference #5010 stated "POLICY: Standard Precautions are designed for care of all patients in facilities, regardless of diagnosis or presumed infection status, to reduce the risk of transmission from both recognized and unrecognized sources of infection. ... Standard Precautions include: ... Gloves: To be worn when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin and other contaminated items, i.e. equipment. Gloves do NOT take the place of hand hygiene. Hands are to be washed after removing gloves. Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms." 5. The agency policy dated 7/24/17, titled "HAND HYGIENE - CDC [Centers for Disease Control] GUIDELINES," Reference #5011 stated "Purpose: To provide guidelines for effective hand hygiene, in order to prevent the transmission			

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	of bacteria, germs and infections. ... The CDC has recommended guidelines on when to use non-antimicrobial soap and water, and antimicrobial soap and water or an alcohol-based had rub. ... After coming in contact with patient's intact skin, i.e., taking a patient's blood pressure, pulse, lifting/moving the patient."			
G 0225 Bldg. 00	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on record review, observation, and interview the agency failed to ensure that the home health aide (HHA) followed the tasks on the aide care plan for 1 of 11 records reviewed (#4). Findings include: 1. The clinical record of patient #4 was reviewed on 1/4/18 and indicated a start of care date of 11/2/17. The record contained a plan of care dated 11/2/17-12/31/17. A. The agency document titled " Aide Care Plan," indicated " shower every visit ...	G 0225	o:p> o:p> /span> **On 1-10-18**, the Director of Nursing in-serviced the home health aide, Employee D, on following the patient's care plan by documenting each completed task and reviewed patient's care plan with home health aide, Employee D. The home health aide, Employee D, was instructed on how to complete the visit note. A sample visit note was provided to the home health aide, Employee D. The home health aide, Employee D, was instructed to document if the patient refuses to have task performed, the home	01/11/2018

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	hair care every visit, shampoo every visit ... Check pressure areas every visit." B. During observation on 1/9/18 at 10:30 AM employee D, HHA was observed providing personal care. The HHA assisted the patient in the shower, then patient removed robe. The HHA then washed the patient's back. The patient then finished the bath alone while the HHA stood outside of the shower curtain. The HHA failed to complete the entire shower (only washing the back), complete hair care, shampoo or check for pressure areas. The HHA failed to ask the patient if these tasks could be completed. C. During an interview on 1/9/18 at 2: 25 PM, the director of nursing stated that all tasks on the aide care plan should be completed every visit (if they are marked to be completed every visit) unless the patient refuses. D. During an interview on 1/9/18 at 2:26 PM, the director of nursing stated that it depends on the condition of the patient to what tasks are completed. 2. The undated agency job description titled "HOME HEALTH AIDE JOB DESCRIPTION," Reference		health aide, Employee D, must document the patient's refusal and notify case manager. **On 1-11-18**, the Director of Nursing made visit with the home health aide, Employee D, to the patient's home to observe the aide performing and documenting all tasks on the patient's care plan. The home health aide, Employee D, offered to perform all tasks on the patient's care plan. The Director of Nursing reviewed the home health aide's, Employee D, visit note to ensure all tasks were offered then completed or documented as refused. The home health aide's, Employee D, visit note was compliant according to patient #4's care plan **The Agency will prevent the deficiency from recurring by:** **On 1-11-18 and ongoing,** the Administrator, Director of Nursing or designee will perform a 100% ongoing audits on all home health aides visit notes and will educate home health aides upon hire and with every new patient on following the patient's care plan and documenting all tasks on the patient's care plan. If the visit note does not match the care plan, the RN Case Manager will complete a joint visit with the home health aide and the patient	

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	#4HRDJD004-12/4 stated "Performs personal care activities contained in a written assignment by the Nursing Supervisor." 3. The agency policy dated 7/24/17, titled "PLAN OF CARE," Reference #10004 stated "All Clinical services shall be implemented only in accordance with a plan of care established by a physician's written orders."		to review the patient's care plan. If a revised care plan is necessary, the Case Manager will update and educate the home health aide and patient. Upon review of the care plan and no revision is needed, the home health aide will be in-serviced on proper completion of the visit note and proper documentation of their visit note. The Administrator, Director of Nursing or designee **are responsible for correcting the deficiency and preventing it from recurring.** **The deficiency will be corrected by (date):** 1-11-18	
G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.	G 0236	o:p=""> ="" span="">**G236 Initial**	01/18/2018

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	Based on record review and interview the agency failed to ensure that an initial assessment visit was documented for 11 of 11 records reviewed (#1,2,3,4,5,6,7,8,9,10,11). Findings include: 1. The clinical record of patient #1 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained a plan of care dated 11/24/17-1/22/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/25/17 was the only assessment completed upon start of care. 2. The clinical record of patient #2 was reviewed on 1/4/18 and indicated a start of care date of 10/16/17. The record contained a plan of care dated 12/16/17-2/12/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/16/17 was the only assessment completed upon start of care.		**assessment documentation needs to be clarified:** How will the agency ensure there is documentation that the initial assessments were completed the same day/same visit as the comprehensive assessments versus only indicating on the referral sheet? **The agency has corrected the deficiency by:** This deficiency was corrected on 2.2.18. Page 2 of the referral form includes the initial assessment visit note. This form was revised to reflect that page 2 is the **initial assessment visit note**. The RN performs the initial assessment visit, signs and dates when the initial assessment visit note has been completed on page 2. The RN then completes the comprehensive assessment which includes a signature and date. The RN will also document on page 24 of the comprehensive assessment that "The Initial Assessment was performed on (date) and (time). Please see the attachment. **The agency will prevent the deficiency from recurring by:** All RN staff will be in-serviced by 2.5.18 and all new RN's will be in-serviced upon hire regarding the initial assessment visit to be completed the same day as the comprehensive assessment. Also, all RN's will be in-serviced on documentation of the initial	

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	3. The clinical record of patient #3 was reviewed on 1/5/18 and indicated a start of care date of 10/31/17. The record contained a plan of care dated 10/31/17-12/29/17. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/31/17 was the only assessment completed upon start of care. 4. The clinical record of patient #4 was reviewed on 1/4/18 and indicated a start of care date of 11/2/17. The record contained a plan of care dated 11/2/17-12/31/17. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 11/2/17 was the only assessment completed upon start of care. 5. The clinical record of patient #5 was reviewed on 1/4/18 and indicated a start of care date of 9/19/17. The record contained a plan of care dated 11/18/17-1/6/18. The record failed to evidence an initial assessment was documented.		assessment visit date/time on page 24 of the comprehensive assessment visit. Effective 2.5.18 and ongoing, the DON/ADON/QI Coordinator or designee will complete 100% ongoing audits on all admits to verify that the initial assessment and the comprehensive assessments were completed on the same day/same visit. The administrator, Director of Nursing, Assistant Director of Nursing/Quality Improvement Coordinator or designee **are responsible for correcting the deficiency and preventing it from recurring** and will ensure the agency's ongoing compliance with performance and documentation of the initial assessment visits and the comprehensive assessment visits on the same day/visit. **The deficiency will be corrected by 2.2.18** ="" span="">	

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	A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/19/17 was the only assessment completed upon start of care. 6. The clinical record of patient #6 was reviewed on 1/5/18 and indicated a start of care date of 10/6/17. The record contained a plan of care dated 12/5/17-2/2/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/6/17 was the only assessment completed upon start of care. 7. The clinical record of patient #4 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care. 8. The clinical record of patient #8 was reviewed on 1/5/18 and indicated a start of			

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	care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care. 9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained a plan of care dated 9/25/17-11/23/17. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/25/17 was the only assessment completed upon start of care. 10. The clinical record of patient #10 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 9/22/17-11/20/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only			

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	assessment completed upon start of care. 11. The clinical record of patient #11 was reviewed on 1/9/18 and indicated a start of care date of 11/8/17. The record contained a plan of care dated 111/8/17-1/6/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 11/8/17 was the only assessment completed upon start of care. 12. During an interview on 1/5/17 at 2:14 PM, the assistant director of nursing stated that the initial assessment and comprehensive assessment are combined into one assessment form when completing the start of care. 13. During an interview on 1/5/17 at 2:15 PM, the director of nursing stated that both the initial assessment and comprehensive assessment are completed in the home on start of care. 14. The agency policy dated 7/24/17, titled "COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS," Reference #7011 stated "Right at Home complies with all applicable federal, state, and local laws			

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	and regulations regarding all aspects of home health business practices." 15. The agency policy dated 7/24/17, titled "ACCEPTANCE/ADMISSION OF PATIENTS," Reference #10001 stated "If patient meets HHA [Home Health Agency] criteria, an initial comprehensive assessment is performed by a Registered Nurse, including drug regime review." The agency policy dated 7/24/17, titled "PLAN OF CARE," Reference #10004 stated "All Clinical services shall be implemented only in accordance with a plan of care established by a physician's written orders." 16. The agency policy dated 7/24/17, titled "ASSESSMENT - NURSING," Reference #10008 stated "Purpose: To provide each HHA [Home Health Agency] patient ... with a comprehensive assessment ... and/or services within an appropriate time frame, as outlined by Federal regulatory requirements. ... Admission assessments shall be performed by a Registered Nurse within: 48 hours of referral ... Procedure: A Registered Nurse shall complete an initial comprehensive assessment of the patient's needs for care, treatment and/or services within the time frame specified in the above policy. ...The initial comprehensive			

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RIGHT AT HOME, INC	1135 BROADWAY STREET ANDERSON, IN 46012

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	assessment form with all areas being addressed and documented. ...". 17. The agency policy dated 7/24/17, titled "INTERDISCIPLINARY PATIENT ASSESEMENTS AND REASSESSMENTS," Reference #10010 stated "A Registered Nurse completes all initial evaluation assessments except in those instances where the physician has ordered only therapy services. ... Skilled Nursing: Evaluates the patient in his/her place of residence for appropriateness of care, treatment and/or services requested within: 48 hours of referral." 18. The undated agency job description titled "ADMINISTRATOR," Reference #4014 stated "Job Summary: Organizes and directs the HHA's [Home Health Agency's] day-to-day operations, ensuring compliance with State and Federal regulations." 19. The undated agency job description titled "DIRECTOR OF NURSING JOB DESCRIPTION," Reference #4HRDJD004-12/4 stated "Maintains compliance to all ... regulatory requirements." 20. The undated agency job description			

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	titled "ALTERNATE DIRECTOR OF NURSING JOB DESCRIPTION," Reference #4HRDJD004-12/4 stated "Maintains compliance to all ... regulatory requirements."			
N 0470 Bldg. 00	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. Based on record review, observation, and interview the agency failed to ensure that agency staff followed infection control policies for 1 of 4 home visits (#4). Findings include: 1. The clinical record of patient #4 was reviewed on 1/4/18 and indicated a start of care date of 11/2/17. The record contained a plan of care dated 11/2/17-12/31/17. A. During observation on 1/9/18 at 10:30 AM employee D, HHA (Home Health Aide) was observed providing personal care. The HHA assisted the patient in the shower. With gloved hands, the HHA rubbed soap all over the	N 0470	o:p=""> N470: What is the agency's plan to ensure that this deficiency will not occur with the entire clinical staff? **The agency has corrected this deficiency:** On 1.11.18, All clinical staff completed in-services consisting of Hand Hygiene and Infection Control videos, as well as, in service tests. The Director of Nursing educated all clinical staff on policy 5010-Standard Precautions, Policy 5011 Hand Hygiene and N131 Glove Technique. All staff was competency checked on Hand Hygiene and Glove Technique. 100% of all clinical staff passed in-service tests and proper hand hygiene and glove technique. **The agency will prevent the deficiency from recurring by:**	01/11/2018

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	washcloth with hands. The HHA then washed the patient's back. While patient finished the shower alone, the HHA stood outside of the shower. HHA then dried patients' back and assisted with applying robe. HHA then assisted with applying brief and pushed patient to room using rollator walker. The HHA failed to remove gloves, complete hand hygiene, and apply new gloves in between patient tasks. B. At the end of care the HHA cleaned work station, picked up dirty linen and removed gloves. The HHA failed to complete hand hygiene after care was completed and gloves were removed. 2. During an interview on 1/9/18 at 2:22 PM, the director of nursing stated that glove changes should occur anytime gloves are soiled or in between tasks. 3. During an interview on 1/9/18 at 2:21 PM, the director of nursing stated that hand hygiene should be completed before care, during care, anytime gloves are changed, when gloves are soiled and after care. 4. The agency policy dated 7/24/17, titled "STANDARD PRECAUTION," Reference #5010 stated "POLICY: Standard Precautions are designed for care of all		Upon hire and annually, all clinical staff will complete in-services consisting of Hand Hygiene, Standard Precautions, and Glove Technique. All clinical staff will be competency checked upon hire, at 90 day evaluation, annually and as needed. On 1.10.18 and Ongoing: All clinical staff will be educated on Hand Hygiene, Standard Precautions, Glove Technique, PPE Usage, and Infection Control Policies with videos, return demonstration, upon hire, at 90 day evaluation, annually and as needed. The Administrator and Director of Nursing **are responsible for ensuring that this deficiency does not recur.** **The deficiency was corrected by 1.11.18**	

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	patients in facilities, regardless of diagnosis or presumed infection status, to reduce the risk of transmission from both recognized and unrecognized sources of infection. ... Standard Precautions include: ... Gloves: To be worn when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin and other contaminated items, i.e. equipment. Gloves do NOT take the place of hand hygiene. Hands are to be washed after removing gloves. Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms." 5. The agency policy dated 7/24/17, titled "HAND HYGIENE - CDC [Centers for Disease Control] GUIDELINES," Reference #5011 stated "Purpose: To provide guidelines for effective hand hygiene, in order to prevent the transmission of bacteria, germs and infections. ... The CDC has recommended guidelines on when to use non-antimicrobial soap and water, and antimicrobial soap and water or an alcohol-based had rub. ... After coming in contact with patient's intact skin, i.e., taking a patient's blood pressure, pulse, lifting/moving the patient."			

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N 0494 Bldg. 00	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on record review, interview, and policy review the agency failed to obtain proper consent for treatment before the initiation of care for 1 out of 11 records reviewed (# 8). Findings include: 1. The clinical record of patient #8 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence signed consents prior to the initiation of care.	N 0494	o:p> o:p> o:p> 1. On **1-15-18**, clarification order was written and faxed to patient #8's physician (copy included). 2. On **1-16-18** the clarification order was signed by patient #8's physician. 3. On **1-17-18**, patient #8 was notified of the clerical error, a home visit was made and patient #8 was given a copy of the signed physician clarification order. Patient #8 verbalized understanding that the consent was reviewed and signed on	01/17/2018

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	A. The agency document titled "Comprehensive Adult Nursing Assessment," was completed and dated 9/22/17. B. The agency consent document titled " Emergency Plan," was completed and dated 9/23/17. C. The agency consent document titled " Right At Home, Inc.," stated " Home care services have been initiated on 9/23/17." This document was signed by the patient and employee B on 9/23/17. D. The agency consents document titled " Admission Service Agreement Home Health," was initialed and signed by the patient and that employee B on 9/23/17. E. During an interview on 1/5/18 at 2:15 PM, the assistant director of nursing stated that the start of care date is the date that consents are signed.		9-22-17 along with the comprehensive assessment. Patient #8 co-signed physician order, retained a copy, and original was place on patient #8's chart. **The agency will prevent the deficiency from recurring by:** The Administrator, Director of Nursing, Quality Improvement Coordinator or designee will complete 100% audit of all admit. These audits will be completed within 48 hours of submission of admission documents. The documentation audit is to ensure dates of admission and consent which includes the patients' rights correlate and date errors do not recur. Audits will be ongoing to ensure compliance and consistency of all medical records. All registered nurses will be oriented upon hire regarding assessment date and consent date correlating. The Administrator, Director of Nursing, Quality Improvement Coordinator or designee **are responsible for correcting the deficiency and preventing it from recurring.**	

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			The deficiency will be corrected by (date): 1-17-18	
N 0540 Bldg. 00	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on record review and interview the agency failed to ensure that an initial assessment visit was documented for 11 of 11 records reviewed (#1,2,3,4,5,6,7,8,9,10,11). Findings include: 1. The clinical record of patient #1 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained a plan of care dated 11/24/17-1/22/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/25/17 was the only assessment completed upon start of care.	N 0540	o:p=""> **N540 Initial assessment documentation needs to be clarified:** How will the agency ensure there is documentation that the initial assessments were completed the same day/same visit as the comprehensive assessments versus only indicating on the referral sheet? **The agency has corrected the deficiency by:** This deficiency was corrected on 2.2.18. Page 2 of the referral form includes the initial assessment visit note. This form was revised to reflect that page 2 is the **initial assessment visit note**. The RN performs the initial assessment visit, signs and dates when the initial assessment visit note has been completed on page 2. The RN then completes the comprehensive assessment which	01/18/2018

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	2. The clinical record of patient #2 was reviewed on 1/4/18 and indicated a start of care date of 10/16/17. The record contained a plan of care dated 12/16/17-2/12/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/16/17 was the only assessment completed upon start of care. 3. The clinical record of patient #3 was reviewed on 1/5/18 and indicated a start of care date of 10/31/17. The record contained a plan of care dated 10/31/17-12/29/17. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/31/17 was the only assessment completed upon start of care. 4. The clinical record of patient #4 was reviewed on 1/4/18 and indicated a start of care date of 11/2/17. The record contained a plan of care dated 11/2/17-12/31/17. The record failed to evidence an initial		includes a signature and date. The RN will also document on page 24 of the comprehensive assessment that "The Initial Assessment was performed on (date) and (time). Please see the attachment. **The agency will prevent the deficiency from recurring by:** All RN staff will be in-serviced by 2.5.18 and all new RN's will be in-serviced upon hire regarding the initial assessment visit to be completed the same day as the comprehensive assessment. Also, all RN's will be in-serviced on documentation of the initial assessment visit date/time on page 24 of the comprehensive assessment visit. Effective 2.5.18 and ongoing, the DON/ADON/QI Coordinator or designee will complete 100% ongoing audits on all admits to verify that the initial assessment and the comprehensive assessments were completed on the same day/same visit. The administrator, Director of Nursing, Assistant Director of Nursing/Quality Improvement Coordinator or designee **are responsible for correcting the deficiency and preventing it from recurring** and will ensure the agency's ongoing compliance with performance and documentation of the initial assessment visits and the comprehensive assessment visits	

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	assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 11/2/17 was the only assessment completed upon start of care. 5. The clinical record of patient #5 was reviewed on 1/4/18 and indicated a start of care date of 9/19/17. The record contained a plan of care dated 11/18/17-1/6/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/19/17 was the only assessment completed upon start of care. 6. The clinical record of patient #6 was reviewed on 1/5/18 and indicated a start of care date of 10/6/17. The record contained a plan of care dated 12/5/17-2/2/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 10/6/17 was the only assessment completed upon start of care. 7. The clinical record of patient #4 was		on the same day/visit. **The deficiency will be corrected by 2.2.18** ="" span="">	

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	reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care. 8. The clinical record of patient #8 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care. 9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained a plan of care dated 9/25/17-11/23/17. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing			

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	Assessment," dated 9/25/17 was the only assessment completed upon start of care. 10. The clinical record of patient #10 was reviewed on 1/5/18 and indicated a start of care date of 9/22/17. The record contained a plan of care dated 9/22/17-11/20/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care. 11. The clinical record of patient #11 was reviewed on 1/9/18 and indicated a start of care date of 11/8/17. The record contained a plan of care dated 111/8/17-1/6/18. The record failed to evidence an initial assessment was documented. A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 11/8/17 was the only assessment completed upon start of care. 12. During an interview on 1/5/17 at 2:14 PM, the assistant director of nursing stated that the initial assessment and comprehensive assessment are combined into one assessment form when completing			

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	the start of care. 13. During an interview on 1/5/17 at 2:15 PM, the director of nursing stated that both the initial assessment and comprehensive assessment are completed in the home on start of care. 14. The agency policy dated 7/24/17, titled "COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS," Reference #7011 stated "Right at Home complies with all applicable federal, state, and local laws and regulations regarding all aspects of home health business practices." 15. The agency policy dated 7/24/17, titled "ACCEPTANCE/ADMISSION OF PATIENTS," Reference #10001 stated "If patient meets HHA [Home Health Agency] criteria, an initial comprehensive assessment is performed by a Registered Nurse, including drug regime review." The agency policy dated 7/24/17, titled "PLAN OF CARE," Reference #10004 stated "All Clinical services shall be implemented only in accordance with a plan of care established by a physician's written orders." 16. The agency policy dated 7/24/17, titled "ASSESSMENT - NURSING," Reference			

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	#10008 stated "Purpose: To provide each HHA [Home Health Agency] patient ... with a comprehensive assessment ... and/or services within an appropriate time frame, as outlined by Federal regulatory requirements. ... Admission assessments shall be performed by a Registered Nurse within: 48 hours of referral ... Procedure: A Registered Nurse shall complete an initial comprehensive assessment of the patient's needs for care, treatment and/or services within the time frame specified in the above policy. ...The initial comprehensive assessment form with all areas being addressed and documented. ...". 17. The agency policy dated 7/24/17, titled "INTERDISCIPLINARY PATIENT ASSESEMENTS AND REASSESSMENTS," Reference #10010 stated "A Registered Nurse completes all initial evaluation assessments except in those instances where the physician has ordered only therapy services. ... Skilled Nursing: Evaluates the patient in his/her place of residence for appropriateness of care, treatment and/or services requested within: 48 hours of referral." 18. The undated agency job description titled "ADMINISTRATOR," Reference #4014 stated "Job Summary: Organizes			

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	and directs the HHA's [Home Health Agency's] day-to-day operations, ensuring compliance with State and Federal regulations." 19. The undated agency job description titled "DIRECTOR OF NURSING JOB DESCRIPTION," Reference #4HRDJD004-12/4 stated "Maintains compliance to all ... regulatory requirements." 20. The undated agency job description titled "ALTERNATE DIRECTOR OF NURSING JOB DESCRIPTION," Reference #4HRDJD004-12/4 stated "Maintains compliance to all ... regulatory requirements."			