

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER GENTIVA HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8606 ALLISONVILLE RD STE 350 INDIANAPOLIS, IN 46250
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G0000	<p>This visit was for a home health federal recertification survey</p> <p>Survey dates: 5/1-5/4/12</p> <p>Facility #005306 Medicaid# 100263840</p> <p>Survey Team:</p> <p>Dawn Snider, RN, PHNS-Team Leader Miriam Bennett, RN, PHNS- Team Member Ingrid Miller, RN, PHNS-Team Member</p> <p>Census Service Type:</p> <p>Skilled Patients: 5,877 Home Health Aide Only Patients: 0 Personal Service Only Patients: 0 Total: 5,877</p> <p>Sample:</p> <p>RR w HV: 10 RR w/o HV: 9</p> <p>Total RR: 19</p> <p>Quality Review: Joyce Elder, MSN, BSN,</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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2012

FORM APPROVED

OMB NO. 0938-0391

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	RN May 14, 2012			

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G0101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient's power of attorney was informed of the patient's rights for 1 of 19 records reviewed (Patient #8).</p> <p>Findings</p> <p>1. Clinical record #8, start of care (SOC) 3/6/12, evidenced the patient rights were signed by a Licensed Practical Nurse (LPN) employed by the assisted living facility where the patient resided. The record evidenced the patient had a diagnosis of dementia.</p> <p>On 5/3/12 at 11:05 AM, Employee D, the director of nursing, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions.</p> <p>2. The agency policy titled "Patient rights and notice of information and privacy practices" with no revision date stated, "Policy 1. Each patient admitted or readmitted will be provided a copy of the Patient Bill of Rights and the Notice of Information and Privacy Practices ... The</p>	G0101	<p>Managers of clinical practice will inservice clinical staff on policy 3-8. Specific emphasis will be placed on obtaining signatures and the need to communicate with the POA or appropriate health care representative where the patient is unable to exercise his/her rights secondary to physical or mental impairments. The agency will ensure that all clinicians understand the policy and procedures for obtaining signatures and communicating with the POA or appropriate health care representative when the patient is unable to exercise his/her rights secondary to physical or mental impairments. 100% of consents will be reviewed by the managers of clinical practice at start of care as part of the quality assurance process for the next 30 days. 10% of charts will be audited quarterly to ensure ongoing compliance as part of the clinical record review process.</p>	06/13/2012			

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	patient bill of rights will be discussed with the patient or family to promote understanding ... Where the patient is not able to exercise his / her rights due to physical / mental impairments, family members, and / or significant others may exercise the rights on the patient's behalf."			

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G0110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, document review, agency policy review, observation, and interview, the agency failed to ensure patients were provided written information regarding advance directives that included a description of applicable state law for 10 of 10 home visit observations (# 1 - 10) with the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical records #7 - 10 evidenced the patient had received the admission documents. During home visit observations for Patients # 7 - 10, the admission packet kept in the home failed to evidence the advance directives packet as noted by the following home visit</p>	G0110	<p>On May 1, 2012 the Indiana Advanced Directive addendum was added to the start of care packet. All active patients will be mailed the Indiana Advanced directive information with explanation of the error/omission. Clinicians will be educated to check the start of care packet for the advanced directive information and will answer any questions regarding the omission.</p> <p>The rehab director and managers of clinical practice will ensure that the advanced directives are present in the start of care packet when conducting home supervisory visits. The branch directors in Indianapolis and Greenwood will conduct quarterly audits to ensure that the Indiana Advanced Directive information is present in the packet for clinician use. Clarification has been provided to</p>	06/08/2012			

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	<p>observations:</p> <p>A. On 5/1/12 at 4:05 PM, Patient #7's admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>B. On 5/2/12 at 9:30 AM, Patient #8's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>C. On 5/2/12 at 10:50 AM, Patient #9's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>D. On 5/2/12 at 12:20 PM, Patient #10's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>2. On 5/2/12 at 9:20 AM, Employee M, Registered Nurse (RN), indicated the agency had not included the description of applicable state law concerning advanced directives for the state of Indiana for any patients.</p>		<p>the appropriate administration staff responsible for assembling the start of care packets regarding including the Indiana State Advanced Directives in all start of care packets.</p>	

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	<p>4. Clinical records #1 - 3 evidenced the patient had received the admission documents. During home visit observation for patients #1- 3, the admission packet kept in the home failed to evidence the advance directives as noted by the following home visit observations:</p> <p style="padding-left: 40px;">A. On 5/2/12 at 10:25 AM, Patient #1 admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable state law.</p> <p style="padding-left: 40px;">B. On 5/2/12 at 12:35 AM, Patient #2 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p style="padding-left: 40px;">C. On 5/2/12 at 2:00 PM, Patient #3 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p>5. The undated policy titled "3-10 Advance Directives" states, "2. All adult patients admitted for services will be advised of this right prior to the provision of services and will be provided with written information related to this right,</p>	G0110	<p>On May 1, 2012 the Indiana Advanced Directive addendum was added to the start of care packet. All active patients will be mailed the Indiana Advanced directive information with explanation of the error/omission. Clinicians will be educated to check the start of care packet for the advanced directive information and will answer any questions regarding the omission.</p> <p>The rehab director and managers of clinical practice will ensure that the advanced directives are present in the start of care packet when conducting home supervisory visits. The branch directors in Indianapolis and Greenwood will conduct quarterly audits to ensure that the Indiana Advanced Directive information is present in the packet for clinician use. Clarification has been provided to the appropriate administration staff responsible for assembling the start of care packets regarding including the Indiana State Advanced Directives in all start of care packets.</p>	06/08/2012			

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	<p>Company policies, and state-specific information about advance directives and withholding or forgoing life sustaining care issued by the respective state."</p> <p>3. Clinical records #4 - 6 evidenced the patient had received the admission documents. During home visit observation for patients # 4-6, the admission packet kept in the home failed to evidence the advance directives packet as noted by the following home visit observations:</p> <p>A. On 5/2/12 at 11:30 AM, Patient #4 admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable</p>			

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	<p>state law.</p> <p>B. On 5/2/12 at 4:00 PM, Patient #5 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p>C. On 5/3/12 at 9:00 AM, Patient #6 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p>				

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G0159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>3. Clinical record #7, start of care (SOC) 3/19/12, included a plan of care (POC) for the certification period of 3/19/12 - 5/17/12 that failed to include a the required items. The clinical document titled "Start of Care /Resumption of care - Physical Therapy" and dated 3/19/12 and signed by Employee N and patient #7 stated, "Management of Injectable Medications and proper dosages at the correct times ... Comments Vit [Vitamin] B 12 'the doctor gives it to me once a month'."</p> <p>A. A clinical document titled "Home Health Certification and Plan of Treatment" with a certification period of 3/19/12 - 5/17/12 and signed by the director of nursing on 3/16/12 failed to evidence Vitamin B 12 injections.</p> <p>B. On 5/3/12 at 10:35 AM, the</p>			G0159	<p>All medications will be included on the plan of care and medication profile. Clinicians involved with the care of patient # 7 and clinical record # 8 were educated on 5/9/12. The clinicians verbalized their understanding that all medications needed to be included in the plan of care, in the medication profile, and that all meds listed need a frequency for administration. The staff will be inserviced by the managers of clinical practice to ensure that all medications including route and dosage will be included on the medication profile. Medications that the patient receives at a physician's office will be included in the medication profile. 10% of all clinical records will be audited quarterly for evidence that all medications including route and dosage have been included in the medication profile and plan of care. The Branch Director will inservice the staff on policy 3-12 ensuring the staff has a thorough</p>		06/13/2012

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	<p>director of nursing indicated the Vitamin B 12 injection was not listed on the POC for Patient #7.</p> <p>4. Clinical record #8, SOC 3/6/12, included a plan of care for the certification period 3/6/12 - 5/4/12 that failed to evidence frequency a medication was to be given. The clinical document titled "Home health Certification and Plan of Treatment" with a certification period of 3/6/12 - 5/4/12 and signed by the director of nursing on 3/5/12 stated, "Tylenol 500 MG [milligram] prn [as needed] po [by mouth] for pain or increased temp [temperature]. The frequency the medication was to be administered was not identified.</p> <p>On 5/3/12 at 11:05 AM, the director of nursing indicated the POC failed to indicate frequency of administration was listed for the Tylenol.</p> <p>5. The agency policy titled "3 - 12 Physician's Orders stated, "Content of Physician Orders" stated, "The Plan of Treatment ... covers medications and treatments."</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care included</p>		<p>understanding that all DME that is required to care for the patient is included on the plan of care. The managers of clinical practice will ensure that all DME that is required for patient care is included in the plan of care as part of the quality assurance process. 10% of all clinical records will be audited quarterly for evidence that all DME that is required and listed on OASIS documentation is included in the plan of care. Supervisory visits will be conducted to ensure that all DME in the home is included in the plan of care.</p>				

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	<p>all the required elements in 5 of 19 clinical records (3, 4, 6, 7, and 8) reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 3/19/12, included a plan of care for the certification period 3/19 - 5/17/12 that failed to evidence the patient used a Hoyer lift. Nurses notes dated 4/16/12 evidenced the patient used a Hoyer lift.</p> <p>2. The policy titled "3-12 Physician's Orders" states "CONTENT OF PHYSICIAN'S ORDERS 1. The Plan of Treatment is based on an evaluation of the patient's immediate and long-term needs. It covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items."</p> <p>6. During home visit on 5/2/12 at 11:30 AM, patient #4 was observed to have the following DME (durable medical equipment) in the home: Broda chair,</p>				

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	<p>hospital bed, wheel chair, Hoyer lift, oxygen concentrator. The Home Health Certification and Plan of Care dated 3/29-5/27/12 failed to include the Broda Chair in the DME section.</p> <p>7. During home visit on 5/3/12 at 9:00 AM, patient #6 was observed to have the following DME in the home: walker, Jazzy hover chair, wheeled walker, quad cane, wheel chair, hospital bed, stationary exercise bike. The Home Health Certification and Plan of Care dated 4/4-6/2/12 failed to include the Jazzy hover chair and stationary exercise bike in the DME section.</p> <p>A. On 5/3/12 at 9:45 AM, patient indicated they do not currently use the quad cane and wheeled walker and they do use the stationary bike for leg exercises while sitting in the wheel chair.</p> <p>B. On 5/3/12 at 9:48 AM, employee L confirmed the patient does not use the wheeled walker and quad cane at this time.</p> <p>8. The agency's policy titled "Physician's Orders," #3-12, revised 05/08 states under the section titled "General Information, Content of Physician Orders, 1. The Plan of Treatment is based on an evaluation of the patient's immediate and long-term</p>				

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	needs. It covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items."			

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure 4 of 6 patients (# 2 - 4 and 9) with home health aide services had an aide care plan with complete and clear instructions with the potential to affect all the patients receiving aide services.</p> <p>Findings</p> <p>1. Clinical record #9, start of care (SOC) 6/8/10, failed to evidence an aide care plan with instructions. At a home visit observation on 5/2/12 at 10:50 AM, Employee E, Home health aide (HHA), was observed to give a bed bath and shave to patient #9. Employee E indicated no instructions were present in the home. On 5/2/12 at 10:50 AM, the home chart failed to evidence an aide care plan with instructions.</p> <p>A. Clinical record #9 evidenced an aide care plan dated 3/2/12 and signed by</p>	G0224	<p>The director of nursing and alternate director of nursing will review policy 15-1 with staff and inservice the staff on writing the care plan with complete and clear instructions. The agency will ensure that the staff understand that all activities that are to be provided to the patient by the home health aide are clearly defined in the care plan. The agency will ensure that the home health aide will follow the care plan, provide all of the activities as listed on the care plan, and have the care plan present in the home. Personal care plans will be reviewed by the managers of clinical practice during the quality assurance process at all time points to ensure that the care plan is complete and that it accurately reflects the needs as reported on the comprehensive clinical assessments. 10% of all home health aide clinical records will be identified quarterly and audited for evidence that the personal care plan is complete, the home health follows the care plan, and that there is evidence of communication with the supervising clinician when</p>	06/13/2012			

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	<p>Employee C, Registered Nurse, with tasks for the aide. This plan was not included in the home record or available for the Employee E, HHA.</p> <p>B. On 5/3/12 at 10:30 AM, the director of nursing and the administrator indicated patient #9's home chart did not have an aide care plan for Employee E to follow while caring for the patient.</p> <p>2. Clinical record #2, start of care 3/7/12, included an aide plan of care dated 3/7/12 signed by the registered nurse that failed to evidence the frequency of the bath for the patient.</p> <p>3. Clinical record #3, start of care 3/19/12 included an aide plan of care dated 3/20/12 signed by the registered nurse that failed to evidence the frequency of the bath for the patient.</p> <p>4. Clinical record #4, start of care 3/29/12, contained a Personal Care Plan dated 3/30/12 by the RN (Registered Nurse). The Personal Care Plan failed to include a frequency for the patient to receive a complete bed bath, bedpan / urinal, and incontinent bowel and bladder care. Activity section is marked for Transfer to Bed/Chair with Assist, but then is crossed out.</p>		<p>patients refuse care plan interventions. Monthly supervisory visits will occur to ensure that the personal care plan is in the home and to ensure that the duties assigned to the aide are performed as indicated on the care plan.</p>	

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	<p>A. The "Activity" section of the Personal Care Visit Reports dated 4/27 and 4/25 indicate Hoyer lift was performed. The "Activity" section of the was not indicated as being assigned by the RN on the Personal Care Plan dated 3/30/12.</p> <p>B. Personal Care Visit Report dated 4/3/12 indicates "Transfer to Bed/Chair with Assist" was performed. Personal Care Plan does not include activity instructions.</p> <p>C. During interview on 5/2/12 at 2:55 PM, employee O indicated the "Activity" section of the Personal Care Plan for record #4 is correct, that the aide is not assigned to do activity with patient. Also, the Hoyer lift should have been added to the activity section once the aide was verified as being competent with the Hoyer lift.</p> <p>5. The agency's policy titled "Home Health Aide," #15-1, not dated, states, under the section "Coverage," "9. The aide must be assigned by the registered nurse with written instructions for all procedures the aide performs and instructions for reporting changes in the patient's condition. Services must comply with state regulations and company</p>			

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	<p>policy. 10. The aide can only perform the tasks assigned on the aide instructions.</p> <p>11. The aide must perform all tasks as assigned, or notify the supervisor if changes are needed in the assignment.</p> <p>12. Supervisory visits for home health aides are required on all skilled cases at least every 14 days regardless of the payer." Under the section "Documentation" the policy states "7. The aide instructions must document the duties assigned to the aide, (including the frequency of each task if not every visit) instructions for special procedures and parameters for observing / reporting."</p>				

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G0225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record review, home visit observation, policy review, and interview, the agency failed to ensure that 1 of 2 records (#9) with home visit observations of home health aide services followed the aide care plan instructions.</p> <p>Findings</p> <p>1. At a home visit observation on 5/2/12 at 10:50 AM, Employee E, Home Health Aide, was observed to give a bed bath and shave to patient #9. During this bath, no foot care was done despite instructions on the aide care plan to complete foot care at each visit. The aide care plan dated 3/2/12 and signed by Employee C, Registered Nurse, stated, "Foot care ea [each] visit."</p> <p>On 5/3/12 at 10:30 AM, the director of nursing and the administrator indicated the aide was to wash the feet at each visit as directed by the aide care plan.</p> <p>2. The agency policy titled "3-11 Care Planning" stated, "The written</p>	G0225	<p>The director of nursing and alternate director of nursing will review policy 15-1 with staff and inservice the staff on writing the care plan with complete and clear instructions. The agency will ensure that the staff understand that all activities that are to be provided to the patient by the home health aide are clearly defined in the care plan. The agency will ensure that the home health aide will follow the care plan, provide all of the activities as listed on the care plan, and have the care plan present in the home. Personal care plans will be reviewed by the managers of clinical practice during the quality assurance process at all time points to ensure that the care plan is complete and that it accurately reflects the needs as reported on the comprehensive clinical assessments. 10% of all home health aide clinical records will be identified quarterly and audited for evidence that the personal care plan is complete, the home health follows the care plan, and that there is evidence of communication with the supervising clinician when patients refuse care plan interventions. Monthly</p>	06/13/2012			

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	instructions for the aide or personal care worker will be prepared by the registered nurse and / or other appropriate professional who is supervising or managing the care of the patient. These instructions will serve as the "care plan" for the aide or personal care worker."		supervisory visits will occur to ensure that the personal care plan is in the home and to ensure that the duties assigned to the aide are performed as indicated on the care plan.	

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G0229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 2 of 6 records reviewed (#2 and #3) of patients receiving home health and skilled services with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical Record #2, start of care 3/7/12, included a plan of care for the certification period 3/19 - 5/17/12 with orders for skilled and home health aide services. The record failed to evidence documentation of supervisory visits of the home health aide.</p> <p>2. Clinical Record #3, start of care 3/19/12, included a plan of care for the certification period 3/7 - 5/5/12 with orders for skilled and home health aide services. The record failed to evidence documentation of supervisory visits until 4/12/12.</p>			G0229	<p>The home health agency will ensure that home health aide supervision is performed no less frequently than every 2 weeks. The managers of clinical practice will inservice the staff at IDT on the requirements of home health aide supervision. The home health agency will utilize "Casematch", our electronic scheduling system, to proactively capture and plan for upcoming supervisory visits at weekly meetings. 10% of charts will be audited quarterly for evidence that home health aide supervision has been completed within 14 days.</p>		06/13/2012

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	<p>3. On 5/3/12 at 4:30 PM, employee O indicated there was no additional documentation to evidence home health aide supervisory visits. Employee O also indicated that the agency was working to improve their documentation of aide supervisory visits.</p> <p>4. The undated policy titled, "15-1 Home Health Aide" states, "Documentation ... #5 The record must indicate that supervisory visits were made at least every 14 days."</p>			

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review, home visit observation, policy review, and interview, the agency failed to ensure the medication profile was accurate for 3 of 19 records reviewed (Clinical records #3, 7, and 8).</p> <p>Findings</p> <p>1. Clinical record #7, start of care (SOC) 3/19/12, failed to evidence a medication profile had been updated with all of the patient's medications. A clinical record document titled "Medication profile" and signed by Employee N, Physical Therapist, failed to list Vitamin B 12 injection. The clinical document titled "Start of Care /Resumption of care - Physical Therapy" and dated 3/19/12 and signed by Employee N and patient #7 stated, "Management of Injectable Medications and proper dosages at the correct times ... Comments Vit [Vitamin]</p>	G0337	The agency will ensure that the comprehensive assessment includes a review of all meds that the patient is currently using. The medications will be entered in the clinical record and will be updated as the agency becomes aware of changes in the prescribed medications. This review will include medications that the patient receives at a physician's office, over-the-counter drugs, and herbal supplements. The staff will be inserviced by the managers of clinical practice to reinforce that all medications are included in the medication profile, all medications include route and dosage, and that the process for making medication updates is clearly understood. The nursing managers of clinical practice will ensure that all medication updates are reviewed and entered into the clinical record. 100% of charts will be reviewed at each time point as part of the quality assurance process to ensure that the plan of care includes all medications that the patient is currently using. 10% of charts will be reviewed quarterly	06/15/2012			

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	<p>B 12 'the doctor gives it to me once a month'."</p> <p>A. The clinical document titled "Medication Profile" dated 3/19/12 and signed by Employee N failed to list Vitamin B 12 injections as one of the medications ordered by the patient's physician. This document was reviewed by the director of nursing on 3/26/12, 3/30/12, and 4/9/12.</p> <p>B. On 5/3/12 at 10:35 AM, the director of nursing indicated the Vitamin B 12 injection was not listed on the medication profile.</p> <p>2. Clinical Record #8, SOC 3/6/12, failed to evidence the medication profile had been updated with all of the patient's medications and the medication frequencies of administration. On 5/2/12 at 9:30 AM, Employee C, Registered Nurse (RN), was observed to administer zinc oxide around a left ankle wound as ordered for daily wound care.</p> <p>A. A physician's order dated on 4/19/12 and signed by Employee P, RN, stated, "Cleanse wound prior to applying a clean dressing ... Apply zinc oxide to surrounding skin."</p> <p>B. A clinical document titled</p>		for evidence that the medication profile is complete and that medications have been updated in the clinical record.				

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	<p>"Medication Profile" and signed by Employee C on 3/6/12 and reviewed by the director of nursing on 3/6/12 and 5/2/12 failed to list zinc oxide as a medication for the left ankle wound treatment. Additionally, this document stated, "Tylenol 500 mg [milligram] by mouth as needed for pain or increased temperature." There was no frequency noted for how often to give Tylenol to the patient.</p> <p>C. On 5/3/12 at 11:05 AM, the director of nursing indicated medication profile failed to indicate frequency of administration was listed for the Tylenol order and failed to list the zinc oxide used for wound care.</p> <p>3. The agency policy titled "03 - 05 Assessment" stated, "Assessments will be completed by a clinician ... The clinical manager or designee will evaluate all medications the patient is taking for possible adverse reactions ... Medicare - Certified Agencies: In addition to company policy: review of patient's medications 1. At the time of the initial assessment and each subsequent assessment, prescription, over-the-counter drugs, and herbal the patient is taking will be evaluated ... Medications will be entered in the clinical record and will be updated as the agency becomes aware of</p>				

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	changes in the prescribed medications." #4. Clinical record #3 included an occupational therapist (O.T.) visit note dated 4/4/12 that identified a change in medications for the patient. On 4/3/12, there were orders for Humulin 10 units injection 1 time a day with meal and one time a day times five units (prn) in evening if blood sugar over two hundred. Arginine was discontinued. Carbidopa-Levo ER 50/200 tab four times day 4/13/12 was ordered. The changes were not documented on the medication profile.				

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N0494	<p>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.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient's power of attorney was informed of the patient's rights for 1 of 19 records reviewed (Patient #8).</p> <p>Findings</p> <p>1. Clinical record #8, start of care (SOC) 3/6/12, evidenced the patient rights were signed by a Licensed Practical Nurse (LPN) employed by the assisted living facility where the patient resided. The record evidenced the patient had a diagnosis of dementia.</p> <p>On 5/3/12 at 11:05 AM, Employee D,</p>	N0494	Managers of clinical practice will inservice clinical staff on policy 3-8. Specific emphasis will be placed on obtaining signatures and the need to communicate with the POA or appropriate health care representative where the patient is unable to exercise his/her rights secondary to physical or mental impairments. The agency will ensure that all clinicians understand the policy and procedures for obtaining signatures and communicating with the POA or appropriate health care representative when the patient is unable to exercise his/her rights secondary to physical or mental impairments. 100% of consents will be reviewed by the managers of clinical practice at start of care as part of the quality assurance process for the next 30 days.	06/13/2012			

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	<p>the director of nursing, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions.</p> <p>2. The agency policy titled "Patient rights and notice of information and privacy practices" with no revision date stated, "Policy 1. Each patient admitted or readmitted will be provided a copy of the Patient Bill of Rights and the Notice of Information and Privacy Practices ... The patient bill of rights will be discussed with the patient or family to promote understanding ... Where the patient is not able to exercise his / her rights due to physical / mental impairments, family members, and / or significant others may exercise the rights on the patient's behalf."</p>		10% of charts will be audited to ensure ongoing compliance as part of the clinical record review process.		

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N0518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, document review, agency policy review, observation, and interview, the agency failed to ensure patients were provided written information regarding advance directives that included a description of applicable state law for 10 of 10 home visit observations (# 1 - 10) with the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical records #7 - 10 evidenced the patient had received the admission documents. During home visit observations for Patients # 7 - 10, the admission packet kept in the home failed to evidence the advance directives packet as noted by the following home visit observations:</p> <p>A. On 5/1/12 at 4:05 PM, Patient #7's</p>	N0518	<p>On May 1, 2012 the Indiana Advanced Directive addendum was added to the start of care packet. All active patients will be mailed the Indiana Advanced directive information with explanation of the error/omission. Clinicians will be educated to check the start of care packet for the advanced directive information and will answer any questions regarding the omission. The rehab director and managers of clinical practice will ensure that the advanced directives are present in the start of care packet when conducting home supervisory visits. The branch directors in Indianapolis and Greenwood will conduct monthly audits for quarterly to ensure that the Indiana Advanced Directive information is present in the packet for clinician use. Clarification has been provided to the appropriate administration staff responsible for assembling the start of care packets regarding including the Indiana State Advanced Directives in all</p>	06/08/2012	

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	<p>admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>B. On 5/2/12 at 9:30 AM, Patient #8's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>C. On 5/2/12 at 10:50 AM, Patient #9's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>D. On 5/2/12 at 12:20 PM, Patient #10's admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law for advanced directives.</p> <p>2. On 5/2/12 at 9:20 AM, Employee M, Registered Nurse (RN), indicated the agency had not included the description of applicable state law concerning advanced directives for the state of Indiana for any patients.</p> <p>4. Clinical records #1 - 3 evidenced the patient had received the admission</p>		start of care packets.		

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	<p>documents. During home visit observation for patients #1- 3, the admission packet kept in the home failed to evidence the advance directives as noted by the following home visit observations:</p> <p>A. On 5/2/12 at 10:25 AM, Patient #1 admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable state law.</p> <p>B. On 5/2/12 at 12:35 AM, Patient #2 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p>C. On 5/2/12 at 2:00 PM, Patient #3 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p>5. The undated policy titled "3-10 Advance Directives" states, "2. All adult patients admitted for services will be advised of this right prior to the provision of services and will be provided with written information related to this right, Company policies, and state-specific information about advance directives and withholding or forgoing life sustaining</p>				

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	<p>care issued by the respective state."</p> <p>3. Clinical records #4 - 6 evidenced the patient had received the admission documents. During home visit observation for patients # 4-6, the admission packet kept in the home failed to evidence the advance directives packet as noted by the following home visit observations:</p> <p>A. On 5/2/12 at 11:30 AM, Patient #4 admission folder kept in the home failed to have copy of the advanced directives that included a description of applicable state law.</p> <p>B. On 5/2/12 at 4:00 PM, Patient #5 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable state law.</p> <p>C. On 5/3/12 at 9:00 AM, Patient #6 admission folder kept in the home failed to have a copy of the advanced directives that included a description of applicable</p>			

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>3. Clinical record #7, start of care (SOC) 3/19/12, included a plan of care (POC) for the certification period of 3/19/12 - 5/17/12 that failed to include a the required items. The clinical document titled "Start of Care /Resumption of care - Physical Therapy" and dated 3/19/12 and signed by Employee N and patient #7 stated, "Management of Injectable Medications and proper dosages at the correct times ... Comments Vit [Vitamin]</p>	N0524	All medications will be included on the plan of care and medication profile. Clinicians involved with the care of patient # 7 and clinical record # 8 were educated on 5/9/12. The clinicians verbalized their understanding that all medications needed to be included in the plan of care, in the medication profile, and that all meds listed need a frequency for administration. The staff will be inserviced by the managers of clinical practice to ensure that all	06/13/2012			

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	<p>B 12 'the doctor gives it to me once a month'."</p> <p>A. A clinical document titled "Home Health Certification and Plan of Treatment" with a certification period of 3/19/12 - 5/17/12 and signed by the director of nursing on 3/16/12 failed to evidence Vitamin B 12 injections.</p> <p>B. On 5/3/12 at 10:35 AM, the director of nursing indicated the Vitamin B 12 injection was not listed on the POC for Patient #7.</p> <p>4. Clinical record #8, SOC 3/6/12, included a plan of care for the certification period 3/6/12 - 5/4/12 that failed to evidence frequency a medication was to be given. The clinical document titled "Home health Certification and Plan of Treatment" with a certification period of 3/6/12 - 5/4/12 and signed by the director of nursing on 3/5/12 stated, "Tylenol 500 MG [milligram] prn [as needed] po [by mouth] for pain or increased temp [temperature]. The frequency the medication was to be administered was not identified.</p> <p>On 5/3/12 at 11:05 AM, the director of nursing indicated the POC failed to indicate frequency of administration was listed for the Tylenol.</p>		<p>medications including route and dosage will be included on the medication profile. Medications that the patient receives at a physician's office will be included in the medication profile. 10% of all clinical records will be audited quarterly for evidence that all medications including route and dosage have been included in the medication profile and plan of care. The Branch Director will inservice the staff on policy 3-12 ensuring the staff has a thorough understanding that all DME that is required to care for the patient is included on the plan of care. The managers of clinical practice will ensure that all DME that is required for patient care is included in the plan of care as part of the quality assurance process. 10% of all clinical records will be audited quarterly for evidence that all DME that is required and listed on OASIS documentation is included in the plan of care. Supervisory visits will be conducted to ensure that all DME in the home is included in the plan of care.</p>				

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	<p>5. The agency policy titled "3 - 12 Physician's Orders stated, "Content of Physician Orders" stated, "The Plan of Treatment ... covers medications and treatments."</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care included all the required elements in 5 of 19 clinical records (3, 4, 6, 7, and 8) reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 3/19/12, included a plan of care for the certification period 3/19 - 5/17/12 that failed to evidence the patient used a Hoyer lift. Nurses notes dated 4/16/12 evidenced the patient used a Hoyer lift.</p> <p>2. The policy titled "3-12 Physician's Orders" states "CONTENT OF PHYSICIAN'S ORDERS 1. The Plan of Treatment is based on an evaluation of the patient's immediate and long-term needs. It covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential,</p>				

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	<p>functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items."</p> <p>6. During home visit on 5/2/12 at 11:30 AM, patient #4 was observed to have the following DME (durable medical equipment) in the home: Broda chair, hospital bed, wheel chair, Hoyer lift, oxygen concentrator. The Home Health Certification and Plan of Care dated 3/29-5/27/12 failed to include the Broda Chair in the DME section.</p> <p>7. During home visit on 5/3/12 at 9:00 AM, patient #6 was observed to have the following DME in the home: walker, Jazzy hover chair, wheeled walker, quad cane, wheel chair, hospital bed, stationary exercise bike. The Home Health Certification and Plan of Care dated 4/4-6/2/12 failed to include the Jazzy hover chair and stationary exercise bike in the DME section.</p> <p>A. On 5/3/12 at 9:45 AM, patient indicated they do not currently use the quad cane and wheeled walker and they do use the stationary bike for leg exercises while sitting in the wheel chair.</p>			

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	<p>B. On 5/3/12 at 9:48 AM, employee L confirmed the patient does not use the wheeled walker and quad cane at this time.</p> <p>8. The agency's policy titled "Physician's Orders," #3-12, revised 05/08 states under the section titled "General Information, Content of Physician Orders, 1. The Plan of Treatment is based on an evaluation of the patient's immediate and long-term needs. It covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items."</p>			

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure 4 of 6 patients (# 2 - 4 and 9) with home health aide services had an aide care plan with complete and clear instructions with the potential to affect all the patients receiving aide services.</p> <p>Findings</p> <p>1. Clinical record #9, start of care (SOC) 6/8/10, failed to evidence an aide care plan with instructions. At a home visit observation on 5/2/12 at 10:50 AM, Employee E, Home health aide (HHA), was observed to give a bed bath and shave to patient #9. Employee E indicated no instructions were present in the home. On 5/2/12 at 10:50 AM, the home chart failed to evidence an aide care plan with instructions.</p> <p>A. Clinical record #9 evidenced an aide care plan dated 3/2/12 and signed by</p>	N0550	The director of nursing and alternate director of nursing will review policy 15-1 with staff and inservice the staff on writing the care plan with complete and clear instructions. The agency will ensure that the staff understand that all activities that are to be provided to the patient by the home health aide are clearly defined in the care plan. The agency will ensure that the home health aide will follow the care plan, provide all of the activities as listed on the care plan, and have the care plan present in the home. Personal care plans will be reviewed by the managers of clinical practice during the quality assurance process at all time points to ensure that the care plan is complete and that it accurately reflects the needs as reported on the comprehensive clinical assessments. 10% of all home health aide clinical records will be identified quarterly and audited for evidence that the personal care plan is complete, the home health follows the care plan, and that there is evidence of communication with the	06/13/2012			

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	<p>Employee C, Registered Nurse, with tasks for the aide. This plan was not included in the home record or available for the Employee E, HHA.</p> <p>B. On 5/3/12 at 10:30 AM, the director of nursing and the administrator indicated patient #9's home chart did not have an aide care plan for Employee E to follow while caring for the patient.</p> <p>2. Clinical record #2, start of care 3/7/12, included an aide plan of care dated 3/7/12 signed by the registered nurse that failed to evidence the frequency of the bath for the patient.</p> <p>3. Clinical record #3, start of care 3/19/12 included an aide plan of care dated 3/20/12 signed by the registered nurse that failed to evidence the frequency of the bath for the patient.</p> <p>4. Clinical record #4, start of care 3/29/12, contained a Personal Care Plan dated 3/30/12 by the RN (Registered Nurse). The Personal Care Plan failed to include a frequency for the patient to receive a complete bed bath, bedpan / urinal, and incontinent bowel and bladder care. Activity section is marked for Transfer to Bed/Chair with Assist, but then is crossed out.</p> <p>A. The "Activity" section of the</p>		<p>supervising clinician when patients refuse care plan interventions. Monthly supervisory visits will occur to ensure that the personal care plan is in the home and to ensure that the duties assigned to the aide are performed as indicated on the care plan.</p>				

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	<p>Personal Care Visit Reports dated 4/27 and 4/25 indicate Hoyer lift was performed. The "Activity" section of the was not indicated as being assigned by the RN on the Personal Care Plan dated 3/30/12.</p> <p>B. Personal Care Visit Report dated 4/3/12 indicates "Transfer to Bed/Chair with Assist" was performed. Personal Care Plan does not include activity instructions.</p> <p>C. During interview on 5/2/12 at 2:55 PM, employee O indicated the "Activity" section of the Personal Care Plan for record #4 is correct, that the aide is not assigned to do activity with patient. Also, the Hoyer lift should have been added to the activity section once the aide was verified as being competent with the Hoyer lift.</p> <p>5. The agency's policy titled "Home Health Aide," #15-1, not dated, states, under the section "Coverage," "9. The aide must be assigned by the registered nurse with written instructions for all procedures the aide performs and instructions for reporting changes in the patient's condition. Services must comply with state regulations and company policy. 10. The aide can only perform the tasks assigned on the aide instructions.</p>						

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	<p>11. The aide must perform all tasks as assigned, or notify the supervisor if changes are needed in the assignment.</p> <p>12. Supervisory visits for home health aides are required on all skilled cases at least every 14 days regardless of the payer." Under the section "Documentation" the policy states "7. The aide instructions must document the duties assigned to the aide, (including the frequency of each task if not every visit) instructions for special procedures and parameters for observing / reporting."</p>				

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 2 of 6 records reviewed (#2 and #3) of patients receiving home health and skilled services with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical Record #2, start of care 3/7/12, included a plan of care for the certification period 3/19 - 5/17/12 with orders for skilled and home health aide services. The record failed to evidence documentation of supervisory visits of the home health aide.</p> <p>2. Clinical Record #3, start of care 3/19/12, included a plan of care for the certification period 3/7 - 5/5/12 with orders for skilled and home health aide</p>	N0606	The home health agency will ensure that home health aide supervision is performed no less frequently than every 2 weeks. The managers of clinical practice will inservice the staff at IDT on the requirements of home health aide supervision. The home health agency will utilize "Casematch", our electronic scheduling system, to proactively capture and plan for upcoming supervisory visits at weekly meetings. 10% of charts will be audited quarterly for evidence that home health aide supervision has been completed within 14 days.	06/13/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER GENTIVA HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8606 ALLISONVILLE RD STE 350 INDIANAPOLIS, IN 46250
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>services. The record failed to evidence documentation of supervisory visits until 4/12/12.</p> <p>3. On 5/3/12 at 4:30 PM, employee O indicated there was no additional documentation to evidence home health aide supervisory visits. Employee O also indicated that the agency was working to improve their documentation of aide supervisory visits.</p> <p>4. The undated policy titled, "15-1 Home Health Aide" states, "Documentation ... #5 The record must indicate that supervisory visits were made at least every 14 days."</p>			