

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/28/2012
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NAME OF PROVIDER OR SUPPLIER 4U HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 W 86TH STREET SUITE 190 INDIANAPOLIS, IN 46260
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G0000	<p>This visit was for an initial home health federal Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: August 27 and August 28, 2012</p> <p>Facility Number: 012906</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 30, 2012</p>	G0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, interview, and job description review, the home health agency failed to provide skilled nursing services and home health aide services in accordance with the plan of care in 10 of 10 records reviewed affecting all the agency's patients. (#1-10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care 7/23/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/23/12 to 9/20/12 with orders that state, "HHA [Home Health Aide]: 3x wk 9 [3 times per week for 9 weeks]." The record failed to evidence all scheduled HHA visits were made as ordered. The week of 7/29/12, only 2 HHA visits were made. The week of 8/5/12, only 1 HHA visit was made. The week of 8/12/12, only 1 HHA visit was made. The week of 8/19/12, only 2 HHA visits were made. There were no missed visit notes or evidence</li> </ol>			G0158	<p>The current missed visits were due to patient cancellation. A new form (Missed Visit Note) has been created to document missed visits. This form documents the patient's name, date of missed visit, type of visit missed, and the reason that the visit was missed. The employee completing the form documents their name, discipline, and signs the form. This form will be completed by the employee whose visit was missed and will be submitted to the Nursing Supervisor. The Nursing Supervisor will send the note to the appropriate physician via fax within 48 hours. The form will be stamped and dated at the time of fax to document that it has been sent to the appropriate physician. All current missed visits were documented using this new form. The appropriate physicians will be notified no later than 9/28/2012. To prevent this from happening in the future, all employees will be trained on this new procedure via an in-service. Employees will be introduced to the Missed Visit Note form and trained on its use. The nursing supervisor and the alternative nursing supervisor will be trained</p>		09/28/2012

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	<p>the doctor was notified of the missed visits in the record.</p> <p>2. Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA [Home Health Aide]: 3x wks/2 hrs x day [3 times per week for 2 hours per day]." The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, no SN visits were made and only 2 HHA visits were made. The week of 7/29/12, no SN visits were made and only 2 HHA visits were made. The week of 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>3. Clinical record #3, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were</p>		<p>on the procedure after a Missed Visit Note has been submitted by another employee. The in-service for all affected employees will be conducted no later than 9/28/2012. A policy will be created no later than 9/28/2012 to explain the use of the Missed Visit Note and who is responsible for the various parts of the workflow surrounding its use. For the next three (3) months, the Administrator will monitor all patients for any undocumented missed visits. Monitoring can be stopped if there are no undocumented missed visits.</p>				

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	<p>made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>4. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA: 3x wk 9/1 hr a day [3 times per week for 9 weeks for 1 hour per day]" The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. The week of 8/5/12, 8/12/12, and 8/19/12, only 2 HHA visits per week were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes</p>						

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	<p>or evidence the doctor was notified of the missed visits in the record.</p> <p>6. Clinical record #6, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/6/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA [Home Health Aide]: 5x wk 2 hr/d wk 9[5 times per week for 2 hours per day for 9 weeks]." The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, no SN visits were made. The week of 8/5/12 and 8/12/12 only 3 HHA visits were made. The week of 8/19/12, only 2 HHA visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>7. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor</p>						

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	<p>was notified of the missed visits in the record.</p> <p>8. Clinical record #8, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>9. Clinical record #9, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>10. Clinical record #10, start of care 7/12/12, included a Home Health</p>						

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	<p>Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>11. On 8/28/12 at 3:10 PM, employee A, President, indicated SN and HHA visits were missed because the patients refused treatment. She indicated she was not aware missed visit notes needed to be sent to the attending physician.</p> <p>12. The job description titled "4 U Home Health Home Health Registered Nurse" revised 2/12 states, "Essential Duties: ... Rendering nursing care and performing treatments and medication administration as ordered by the physician."</p>			

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G0159	<p><b>484.18(a) PLAN OF CARE</b></p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care included durable medical equipment (DME) for 5 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 2, 4, 5, and 7)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 7/23/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/23/12 to 9/20/12. The record also included an OASIS comprehensive assessment dated 7/23/12. Under the heading "DME and Supplies" the registered nurse (RN) checked "cane, tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section</p>	G0159	All patient clinical records have been reviewed to ensure that OASIS data matches the data on CMS-485 (Home Health Certification and Plan of Care). For any patients where the data did not match, CMS-485 was updated to reflect the real data as was observed by the RN during a patient visit. The updated forms were submitted to the appropriate physicians for approval and signature. To ensure this discrepancy does not occur in the future, the Nursing Supervisor will check and verify that all future forms CMS-485 have correct data before being sent out for approval to the appropriate physicians. This monitoring will be continuous.	09/24/2012			

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	<p>was blank.</p> <p>2. Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12. The record also included an OASIS comprehensive assessment dated 7/10/12. Under the heading "DME and Supplies" the RN checked "cane, tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>3. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12. The record also included an OASIS comprehensive assessment dated 7/11/12. Under the heading "DME and Supplies" the RN checked "tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>4. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to</p>						

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	<p>9/8/12. The record also included an OASIS comprehensive assessment dated 7/11/12. Under the heading "DME and Supplies" the RN checked "tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>5. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12. The record also included an OASIS comprehensive assessment dated 7/11/12. Under the heading "DME and Supplies" the RN checked "grab bars, tub/shower bench, and wheelchair." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>6. On 8/28/12 at 2:45 PM, employee F, RN, indicated the DME was not listed on the Plan of Care</p> <p>7. Facility policy titled "Plan of Care", revision date 8/12, states, "The 485, which includes the following plan of care elements, is developed in consultation with staff, client, physician and other providers involved in the client's care</p>						

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	and will serve as the initial plan of care: ... supplies and equipment required."				

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G0170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review, interview, and job description review, the home health agency failed to provide skilled nursing services in accordance with the plan of care in 9 of 10 records reviewed. (#2-10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</li> <li>Clinical record #3, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week</li> </ol>	G0170	<p>The current missed visits were due to patient cancellation. A new form (Missed Visit Note) has been created to document missed visits. This form documents the patient's name, date of missed visit, type of visit missed, and the reason that the visit was missed. The employee completing the form documents their name, discipline, and signs the form. This form will be completed by the employee whose visit was missed and will be submitted to the Nursing Supervisor. The Nursing Supervisor will send the note to the appropriate physician via fax within 48 hours. The form will be stamped and dated at the time of fax to document that it has been sent to the appropriate physician. All current missed visits were documented using this new form. The appropriate physicians will be notified no later than 9/28/2012. To prevent this from happening in the future, all employees will be trained on this new procedure via an in-service. Employees will be introduced to the Missed Visit Note form and trained on its use. The nursing supervisor and the alternative nursing supervisor will be trained on the procedure after a Missed Visit Note has been submitted by another employee. The in-service for all affected</p>	09/28/2012			

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	<p>for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>3. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>4. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes</p>		<p>employees will be conducted no later than 9/28/2012. A policy will be created no later than 9/28/2012 to explain the use of the Missed Visit Note and who is responsible for the various parts of the workflow surrounding its use. For the next three (3) months, the Administrator will monitor all patients for any undocumented missed visits. Monitoring can be stopped if there are no undocumented missed visits.</p>				

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	<p>or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #6, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/6/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>6. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>7. Clinical record #8, start of care 7/10/12, included a Home Health</p>			

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	<p>Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>8. Clinical record #9, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>9. Clinical record #10, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to</p>						

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	<p>evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>10. On 8/28/12 at 3:10 PM, employee A, President, indicated SN visits were missed because the patients refused treatment. She indicated she was not aware missed visit notes needed to be sent to the attending physician.</p> <p>11. The job description titled, "4 U Home Health Home Health Registered Nurse" revised 2/12 states, "Essential Duties: ... Rendering nursing care and performing treatments and medication administration as ordered by the physician."</p>			

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G0229	<p><b>484.36(d)(2) SUPERVISION</b> 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 and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days in 10 of 10 records reviewed of patients who received skilled and home health aide services for longer than 14 days affecting all the agency's patients (#1-10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care 7/23/12, evidenced the patient received skilled and home health aide services. Between 7/23/12 and 8/27/12, only 1 supervisory visit was made on 8/20/12.</li> <li>2. Clinical record #2, start of care 7/10/12, evidenced the patient received skilled and home health aide services. Between 7/10/12 and 8/27/12, only 1 supervisory visit was made on 8/27/12.</li> <li>3. Clinical record #3, start of care 7/9/12, evidenced the patient received</li> </ol>			G0229	<p>Since the end of the initial survey, 8/28/2012, 4U Home Health has reviewed all patient files and has been conducting supervisory visits every 14 days for patients with nursing services and every 30 days for patients without nursing services (HHA only). A spreadsheet will be developed to better plan future supervisory visits no later than 9/28/2012. The Nursing Supervisor will use the spreadsheet to more accurately schedule supervisory visits in the future.</p>		09/28/2012

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	<p>skilled and home health aide services. Between 7/9/12 and 8/27/12, only 1 supervisory visit was made on 8/20/12.</p> <p>4. Clinical record #4, start of care 7/11/12, evidenced the patient received skilled and home health aide services. Between 7/11/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p> <p>5. Clinical record #5, start of care 7/11/12, evidenced the patient received skilled and home health aide services. Between 7/11/12 and 8/27/12, only 1 supervisory visit was made on 8/8/12.</p> <p>6. Clinical record #6, start of care 7/9/12, evidenced the patient received skilled and home health aide services. Between 7/9/12 and 8/27/12, only 1 supervisory visit was made on 8/30/12.</p> <p>7. Clinical record #7, start of care 7/11/12, evidenced the patient received skilled and home health aide services. Between 7/11/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p> <p>8. Clinical record #8, start of care 7/10/12, evidenced the patient received skilled and home health aide services. Between 7/10/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p>			

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	<p>9. Clinical record #9, start of care 7/12/12, evidenced the patient received skilled and home health aide services. Between 7/12/12 and 8/27/12, only 1 supervisory visit was made on 8/22/12.</p> <p>10. Clinical record #10, start of care 7/12/12, evidenced the patient received skilled and home health aide services. Between 7/12/12 and 8/27/12, only 1 supervisory visit was made on 8/22/12.</p> <p>11. On 8/27/12 at 9:45 AM, employee A, President, indicated supervisory visit notes were completed every 30 days. She indicated they call and speak with the patients weekly to make sure they are happy with everything but they only fill out the supervisory visit notes every 30 days. She indicated she was not aware these needed to be completed every 14 days.</p>			

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N0458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.</p> <p>Based on personnel file review and interview, the agency failed to ensure a criminal history or expanded criminal history was applied for within 3 business days of initial patient contact for 3 of 4 employee files reviewed of employees that required a limited criminal history (F, G, and I) and files contained a signed job description for 5 of 6 employee files reviewed of employees that required a signed job description (D, E, F, G, and H) with the potential to affect all patients of the agency.</p> <p>Findings include:</p>	N0458	<p>All job descriptions will be reviewed for accuracy. Any missing job descriptions will be created. Job descriptions will be ready no later than 9/28/2012. The job descriptions will be distributed and signed by all employees no later than 10/5/2012. All current employees have valid criminal history checks. To prevent the deficiency from reoccurring, the Administrator will verify that all new employees sign a job description and document this via the orientation checklist. Also, potential new employees will only be invited for orientation training after a valid criminal history has been received. This can be verified by matching the date of the criminal history and the date</p>	10/05/2012			

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	<p>1. Personnel file D, Supervising Nurse and Alternate Administrator, date of hire 1/10/12, failed to evidence a signed job description</p> <p>2. Personnel file E, Administrator and Alternate supervising nurse, date of hire 5/30/12, failed to evidence a signed job description.</p> <p>3. Personnel file F, Registered Nurse, date of hire 5/7/12, failed to evidence a signed job description. The date of first patient contact was reported to be 5/7/12. The criminal history was dated 5/16/12.</p> <p>4. Personnel file G, Physical Therapist, date of hire 7/27/12, failed to evidence a signed job description. The date of first patient contact was reported to be 7/27/12. The criminal history was dated 8/1/12</p> <p>5. Personnel file H, Physical Therapist, date of hire 7/27/12, failed to evidence a signed job description.</p> <p>6. Personnel file I, Home Health Aide, date of hire was 6/27/12. The date of first patient contact was reported to be 6/27/12. The criminal history was dated 11/29/11.</p>		on the orientation checklist.	

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	7. On 8/28/12 at 3:45 PM, employee A, President, indicated she was not aware everyone needed to have signed job descriptions.			

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N0466	<p>410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k).</p> <p>Based on observation and interview, the agency failed to ensure the confidential medical records of employees were treated as confidential and maintained in separate medical files for 9 of 9 (A, B, C, D, E, F, G, H, and I) personnel files reviewed with the potential to affect all employees of the agency.</p> <p>Findings include:</p> <p>1. On 8/28/12 at 2:30 PM, Employee A, President, retrieved 9 personnel files from a locked file cabinet. Employee A indicated the personnel files held all documentation for employee files including the medical portion of the employee file. Observation evidenced files A, B, C, D, E, F, G, H, and I contained confidential medical information mingled with personnel information in each file.</p> <p>2. On 8/28/12 at 4:00 PM, Employee A</p>	N0466	All employee files were reviewed and any medical information has been moved to a separate folder for each employee. The new employee medical files will be treated as confidential medical information and are being stored in a locked cabinet as are the regular personnel files. The Administrator (and any future HR personnel) will create two separate files, personnel and medical, for all new hired employees in the future. Both files will be stored in a locked cabinet and treated as confidential information.	09/24/2012			

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	indicated not being aware that the medical portion of employee files needed to be kept separate from the administrative portion of the employees file.			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review, interview, and job description review, the home health agency failed to provide skilled nursing services and home health aide services in accordance with the plan of care in 10 of 10 records reviewed. (#1-10)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 7/23/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/23/12 to 9/20/12 with orders that state, "HHA [Home Health Aide]: 3x wk 9 [3 times per week for 9 weeks]." The record failed to evidence all scheduled HHA visits were made as ordered. The week of 7/29/12, only 2 HHA visits were made. The week of 8/5/12, only 1 HHA visit was made. The week of 8/12/12, only 1 HHA visit was made. The week of 8/19/12, only 2 HHA visits were made. There were no missed visit notes or evidence the doctor was notified of the missed</p>	N0522	<p>The current missed visits were due to patient cancellation. A new form (Missed Visit Note) has been created to document missed visits. This form documents the patient's name, date of missed visit, type of visit missed, and the reason that the visit was missed. The employee completing the form documents their name, discipline, and signs the form. This form will be completed by the employee whose visit was missed and will be submitted to the Nursing Supervisor. The Nursing Supervisor will send the note to the appropriate physician via fax within 48 hours. The form will be stamped and dated at the time of fax to document that it has been sent to the appropriate physician. All current missed visits were documented using this new form. The appropriate physicians will be notified no later than 9/28/2012. To prevent this from happening in the future, all employees will be trained on this new procedure via an in-service. Employees will be introduced to the Missed Visit Note form and trained on its use. The nursing supervisor and the alternative nursing supervisor will be trained on the procedure after</p>	09/28/2012			

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	<p>visits in the record.</p> <p>2. Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA [Home Health Aide]: 3x wks/2 hrs x day [3 times per week for 2 hours per day]." The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, no SN visits were made and only 2 HHA visits were made. The week of 7/29/12, no SN visits were made and only 2 HHA visits were made. The week of 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>3. Clinical record #3, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes</p>		<p>a Missed Visit Note has been submitted by another employee. The in-service for all affected employees will be conducted no later than 9/28/2012. A policy will be created no later than 9/28/2012 to explain the use of the Missed Visit Note and who is responsible for the various parts of the workflow surrounding its use. For the next three (3) months, the Administrator will monitor all patients for any undocumented missed visits. Monitoring can be stopped if there are no undocumented missed visits.</p>				

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	<p>or evidence the doctor was notified of the missed visits in the record.</p> <p>4. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA: 3x wk 9/1 hr a day [3 times per week for 9 weeks for 1 hour per day]" The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. The week of 8/5/12, 8/12/12, and 8/19/12, only 2 HHA visits per week were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of</p>			

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	<p>the missed visits in the record.</p> <p>6. Clinical record #6, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/6/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks] ... HHA [Home Health Aide]: 5x wk 2 hr/d wk 9[5 times per week for 2 hours per day for 9 weeks]." The record failed to evidence all scheduled SN and HHA visits were made as ordered. The week of 7/15/12, no SN visits were made. The week of 8/5/12 and 8/12/12 only 3 HHA visits were made. The week of 8/19/12, only 2 HHA visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>7. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the</p>			

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	<p>record.</p> <p>8. Clinical record #8, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>9. Clinical record #9, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>10. Clinical record #10, start of care 7/12/12, included a Home Health Certification and Plan of Care for the</p>						

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	<p>Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>11. On 8/28/12 at 3:10 PM, employee A, President, indicated SN and HHA visits were missed because the patients refused treatment. She indicated she was not aware missed visit notes needed to be sent to the attending physician.</p> <p>12. The job description titled "4 U Home Health Home Health Registered Nurse" revised 2/12 states, "Essential Duties: ... Rendering nursing care and performing treatments and medication administration as ordered by the physician."</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>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care included durable medical equipment (DME) for 5 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 2, 4, 5, and 7)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care</p>	N0524	All patient clinical records have been reviewed to ensure that OASIS data matches the data on CMS-485 (Home Health Certification and Plan of Care). For any patients where the data did not match, CMS-485 was updated to reflect the real data as was observed by the RN during a patient visit. The updated forms were submitted to the appropriate physicians for approval and signature. To ensure this discrepancy does not occur in the future, the Nursing Supervisor will	09/24/2012			

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	<p>7/23/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/23/12 to 9/20/12. The record also included an OASIS comprehensive assessment dated 7/23/12. Under the heading "DME and Supplies" the registered nurse (RN) checked "cane, tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>2. Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12. The record also included an OASIS comprehensive assessment dated 7/10/12. Under the heading "DME and Supplies" the RN checked "cane, tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>3. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12. The record also included an OASIS comprehensive assessment dated</p>		<p>check and verify that all future forms CMS-485 have correct data before being sent out for approval to the appropriate physicians. This monitoring will be continuous.</p>				

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	<p>7/11/12. Under the heading "DME and Supplies" the RN checked "tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>4. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12. The record also included an OASIS comprehensive assessment dated 7/11/12. Under the heading "DME and Supplies" the RN checked "tub/shower bench, and walker." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p> <p>5. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12. The record also included an OASIS comprehensive assessment dated 7/11/12. Under the heading "DME and Supplies" the RN checked "grab bars, tub/shower bench, and wheelchair." These items were not listed on the Home Health Certification and Plan of Care. The "DME and Supplies" section was blank.</p>						

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	<p>6. On 8/28/12 at 2:45 PM, employee F, RN, indicated the DME was not listed on the Plan of Care</p> <p>7. Facility policy titled "Plan of Care", revision date 8/12, states, "The 485, which includes the following plan of care elements, is developed in consultation with staff, client, physician and other providers involved in the client's care and will serve as the initial plan of care: ... supplies and equipment required."</p>			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review, interview, and job description review, the home health agency failed to provide skilled nursing services in accordance with the plan of care in 9 of 10 records reviewed. (#2-10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</li> <li>Clinical record #3, start of care 7/9/12, included a Home Health Certification and Plan of Care for the</li> </ol>	N0537	<p>The current missed visits were due to patient cancellation. A new form (Missed Visit Note) has been created to document missed visits. This form documents the patient's name, date of missed visit, type of visit missed, and the reason that the visit was missed. The employee completing the form documents their name, discipline, and signs the form. This form will be completed by the employee whose visit was missed and will be submitted to the Nursing Supervisor. The Nursing Supervisor will send the note to the appropriate physician via fax within 48 hours. The form will be stamped and dated at the time of fax to document that it has been sent to the appropriate physician. All current missed visits were documented using this new form. The appropriate physicians will be notified no later than 9/28/2012. To prevent this from happening in the future, all employees will be trained on this new procedure via an in-service. Employees will be introduced to the Missed Visit Note form and trained on its use. The nursing supervisor and the alternative nursing supervisor will be trained on the procedure after</p>	09/28/2012			

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	<p>Certification Period from 7/9/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>3. Clinical record #4, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>4. Clinical record #5, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were</p>		<p>a Missed Visit Note has been submitted by another employee. The in-service for all affected employees will be conducted no later than 9/28/2012. A policy will be created no later than 9/28/2012 to explain the use of the Missed Visit Note and who is responsible for the various parts of the workflow surrounding its use. For the next three (3) months, the Administrator will monitor all patients for any undocumented missed visits. Monitoring can be stopped if there are no undocumented missed visits.</p>				

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	<p>made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>5. Clinical record #6, start of care 7/9/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/9/12 to 9/6/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>6. Clinical record #7, start of care 7/11/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/11/12 to 9/8/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p>						

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	<p>7. Clinical record #8, start of care 7/10/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/10/12 to 9/7/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>8. Clinical record #9, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to 9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>9. Clinical record #10, start of care 7/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 7/12/12 to</p>						

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	<p>9/9/12 with orders that state, "SN [Skilled Nurse] 1 wk 9 [1 time per week for 9 weeks]." The record failed to evidence all scheduled SN visits were made as ordered. The week of 7/15/12, 7/29/12, and 8/12/12 no SN visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>10. On 8/28/12 at 3:10 PM, employee A, President, indicated SN visits were missed because the patients refused treatment. She indicated she was not aware missed visit notes needed to be sent to the attending physician.</p> <p>11. The job description titled, "4 U Home Health Home Health Registered Nurse" revised 2/12 states, "Essential Duties: ... Rendering nursing care and performing treatments and medication administration as ordered by the physician."</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 and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 30 days in 8 of 10 records reviewed of patients who received skilled and home health aide services for longer than 30 days with the potential to affect all patients receiving aide services (#2, 3, 4, 6, 7, 8, 9, and 10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #2, start of care 7/10/12, evidenced the patient received skilled and home health aide services. Between 7/10/12 and 8/27/12, only 1 supervisory visit was made on 8/27/12.</li> <li>2. Clinical record #3, start of care 7/9/12, evidenced the patient received skilled and home health aide services. Between 7/9/12 and 8/27/12, only 1 supervisory visit was made on 8/20/12.</li> </ol>	N0606	<p>Since the end of the initial survey, 8/28/2012, 4U Home Health has reviewed all patient files and has been conducting supervisory visits every 14 days for patients with nursing services and every 30 days for patients without nursing services (HHA only). A spreadsheet will be developed to better plan future supervisory visits no later than 9/28/2012. The Nursing Supervisor will use the spreadsheet to more accurately schedule supervisory visits in the future.</p>	09/28/2012			

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	<p>3. Clinical record #4, start of care 7/11/12, evidenced the patient received skilled and home health aide services. Between 7/11/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p> <p>4. Clinical record #6, start of care 7/9/12, evidenced the patient received skilled and home health aide services. Between 7/9/12 and 8/27/12, only 1 supervisory visit was made on 8/30/12.</p> <p>5. Clinical record #7, start of care 7/11/12, evidenced the patient received skilled and home health aide services. Between 7/11/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p> <p>6. Clinical record #8, start of care 7/10/12, evidenced the patient received skilled and home health aide services. Between 7/10/12 and 8/27/12, only 1 supervisory visit was made on 8/21/12.</p> <p>7. Clinical record #9, start of care 7/12/12, evidenced the patient received skilled and home health aide services. Between 7/12/12 and 8/27/12, only 1 supervisory visit was made on 8/22/12.</p> <p>8. Clinical record #10, start of care 7/12/12, evidenced the patient received</p>						

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NAME OF PROVIDER OR SUPPLIER  4U HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 W 86TH STREET SUITE 190 INDIANAPOLIS, IN 46260			
(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>skilled and home health aide services. Between 7/12/12 and 8/27/12, only 1 supervisory visit was made on 8/22/12.</p> <p>9. On 8/27/12 at 9:45 AM, employee A, President, indicated supervisory visit notes are completed every 30 days. She indicated they call and speak with the patients weekly to make sure they are happy with everything but they only fill out the supervisory visit notes every 30 days. She indicated she was not aware these needed to be completed every 14 days.</p>						