

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K108	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2016
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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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G 0000 Bldg. 00	<p>This was a federal home health recertification survey. This was an extended survey.</p> <p>Survey Dates: June 14, 15, 16, 17, 20 and 21, 2016 Partial Extended Dates: June 15, 2016 Extended Dates: June 16, 17, 20 and 21, 2016</p> <p>Facility Number: 004998</p> <p>Medicaid Number: 15K108</p> <p>Census Service Type: Skilled: 8 Home Health Aide Only: 47 Personal Care Only: 0 Total: 55</p> <p>Sample: RR w/HV: 4 RR w/o HV: 13 Total: 17</p> <p>Home Healthcare Associates, Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning June 21, 2016 for being found out of compliance with the</p>	G 0000		
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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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G 0102 Bldg. 00	<p>Conditions of Participation 42 CFR 484.20 Reporting OASIS Information; 484.36 Home Health Aide Services; and 484.48: Clinical Records.</p> <p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on document review, and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment in 1 of 14 records reviewed. (#7)</p> <p>Findings include</p> <p>1. The clinical record for patient #7 was reviewed on 6/17/16. Start of care date 9/22/14. The record failed to evidence the patient had signed a consent for services form and failed to evidence the agency retained notification of patient rights for this admission.</p> <p>2. During interview on 6/17/16, at 11:30</p>	G 0102	<p>A. 1a. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. A. 1b. Agency will complete patient consents prior to provision of services. A. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. Director of Nursing will be responsible for ensuring ongoing compliance with G0102.</p>	07/15/2016

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G 0103 Bldg. 00	<p>AM, the Alternate Administrator stated she could not find the consent for services for 9/22/14.</p> <p>484.10(a)(2) NOTICE OF RIGHTS The HHA must maintain documentation showing that it has complied with the requirements of this section. Based on document review, and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment in 1 of 14 records reviewed. (#7)</p> <p>Findings include</p> <p>1. The clinical record for patient #7 was reviewed on 6/17/16. Start of care date 9/22/14. The record failed to evidence the patient had signed a consent for services form and failed to evidence the agency retained notification of patient rights for this admission.</p> <p>2. During interview on 6/17/16, at 11:30 AM, the Alternate Administrator stated she could not find the consent for services for 9/22/14.</p>	G 0103	<p>A. 1. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. A. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. Director of Nursing will be responsible for ensuring ongoing compliance with G0103.</p>	07/15/2016

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G 0121 Bldg. 00	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, document review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 2 of 5 home visits. (patient # 1 and 14)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient #1 on 6/15/16 at 2:00 PM, employee C (Alternate Nursing Supervisor) was observed providing care. Upon arrival to the home, employee C was observed to wash hands for only 15 seconds total time. 2. During interview on 6/16/16 at 2:40 PM, the Alternate Administrator stated the hand washing policy is 40-60 seconds for the entire hand wash procedure. 3. During home visit observation with patient # 14 on 6/16/16 at 1:45 PM, employee F, home health aide, was observed. After emptying the dishwasher and washing dirty dishes, employee F removed gloves and washed hands for 	G 0121	<p>A. 1a. Agency has educated all staff on the following: 1. Hand Rub Policy and Procedure 2. Hand Washing Policy and Procedure A. 1b. Agency evaluated education using written exam to determine competency regarding hand rub and hand wash policies and procedures. B. Agency will ensure compliance with G0121 by unannounced on site visits until 100% compliance is achieved for 6 months. Agency will track this using a hand rub/hand wash evaluation form completed by RN staff. Director of Nursing will be responsible for ensuring ongoing compliance with G0121.</p>	07/15/2016

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G 0133 Bldg. 00	<p>approximately 5 seconds. Employee F failed to wash her hands longer than 5 seconds.</p> <p>A. After sweeping the kitchen floor and removing gloves, employee F failed to wash her hands for more than 10 seconds.</p> <p>4. The agency's procedure titled "Patient Safety," from the World Health Organization, revised August 2009 stated "Save Lives Clean Your Hands ... How? ... Wash your hands with soap and water when hands are visibly dirty or visibly soiled with blood or other body fluids or after using the toilet. ... Duration of the entire procedure: 20-30 seconds."</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on document review and interview, the Administrator failed to ensure the day-to-day operations of the agency including accuracy of clinical records, employee qualifications oversight, Outcome Assessment Information Set (OASIS) transmission oversight and validation, and Quality</p>	G 0133	Section 1 (G0236): A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. A. 2. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are	07/15/2016

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	<p>Assessment and Performance Improvement (QAPI) review and oversight for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The agency's job description titled "Administrator," no number, no date, stated "Position Overview Responsible for the administration and direction for Home Healthcare Associates' professional, clinical, and clerical services in accordance with established policies, program objectives, and state and federal standards. ... Essential Job Functions Organizes and directs the agency's ongoing functions. ... Employs qualified personnel and ensures adequate staff education and evaluations. ... Evaluates quality of programs and services, report findings to the governing board, implement recommendations for continuous improvement of services offered. ... Evaluates the agency's overall programs and efficiency."</p> <p>2. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>3. During interview on 6/14/16 at 10:35</p>		<p>completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. B.1. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. B. 2. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this standard. C. 1. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. C. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved</p>	

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	<p>AM, the Administrator stated quality assessment includes chart audits which are continual but at least every 60 days and any trends of problems are investigated.</p> <p>4. Clinical record review evidenced the Administrator failed to ensure the accuracy of clinical records and the education and supervision of HHAs and identify the following problems (See G 236 and G 303): Discharge summaries failed to include the summary of care provided, and failed to be completed within 30 days of discharge; Home Health Aide and Registered Nurse visit notes were not recorded timely (See G236); consent for services was not signed prior to providing care (See G 102 and 103); failed to ensure skilled nurse (SN) assessments were completed within 48 hours of ordered dates (See G 170 and G 332); SN followed did not follow plans of care, missed visits were not reported to physician, and plans of care frequencies of serciecs were not accurate (See G 158); OASIS data was not collected on all patients receiving skilled services (See G 334); and failed to oversee the supervision of HHAs by the RNs to ensure appropriate care, scope, and supervision was provided (See G 226 and 229).</p>		<p>for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. D. 1. Agency audited 100% of patient charts to determine the presence of Start of Care(SOC) OASIS. A SOC OASIS is found on 100% of current skilled patient charts. D.2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. E. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. E. 2. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this standard. Section 2 (G0303): A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. A. 2. The Agency will audit 100% of discharge summaries until 100%</p>	

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	<p>5. Home visits evidenced the Administrator failed to ensure all staff were following agency's policies and procedures for infection control (See G 121).</p> <p>6. Employee file reviewed evidenced the Administrator failed to oversee the education and qualifications of employees and failed to identify problems (See G 141): 1 HHA had an expired certification and was not on the Indiana Nurse Aide Registry and was providing care to patients; criminal background checks were not completed within 3 days of starting patient care for 3 of 6 employees; 3 of 4 HHAs did not take a HHA competency test; annual evaluations were not completed for 1 of 2 RNs; and didactic information was not separated from medical information for 1 of 6 files reviewed.</p> <p>7. Review of OASIS data reports evidenced the Administrator failed to oversee and identify the following problems for the agency: monthly transmission of OASIS data (See G 321); the accuracy of OASIS data (see G 322); and monitor and follow up with final validation reports to ensure correction of any identified errors (See G 324).</p> <p>8. The agency's document titled "Quality</p>		<p>compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. Section 3 (G0102): Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. Section 4 (G0103): Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. Section 5 (G0170): A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of</p>	

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	<p>Performance Improvement Review," dated 1st quarter January February and March 2016 failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p> <p>A. The Governing Body board meeting dated 2/15/16 failed to include employee file review, and OASIS review (See G 244).</p> <p>9. The agency's policy titled "Organizational Performance Improvement Plan," no number, no date, stated "Purpose: ... Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment and services. ... Policy: ... Home Healthcare Associates performance improvement plan is evaluated at least annually and revised as necessary. ... Information from departments/services and the findings of discrete performance improvement activities are analyzed to detect trends, patterns of performance or potential problems that may impact more than one (1) department/service. ... Scope of Activities: The cope of the organizational performance improvement program includes an overall assessment</p>		<p>referral or on the physician ordered start-of- care date. B. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. C. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. D. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day</p>	

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	of the efficacy of performance improvement activities with a focus on continually improving care, treatment and services and patient and staff safety practices. The program consists of these focus components: performance improvement, patient/staff safety, quality assessment/improvement and quality control activities. ... Assessment of the performance of the following patient care and organizational functions are included: ... Provision of Care, Treatment and Services ... Leadership ... Surveillance, Prevention and Control of Infection ... Improving Organization Performance."		summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. Section 6 (G0332): A. The Agency will complete all start-of-care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. C. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. Section 7 (G0158): A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician	

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			<p>ordered start-of- care date. B. The Agency scheduling department will actively work to replace employees who "call-off" for their assigned visit. The patient/caregiver will be notified of the call-off and the replacement options. C. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. D. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. E. The Agency will accurately document each patient's visit frequency on all Plans of Care and the Agency will not utilize "0" as a visit frequency. F. The Agency will obtain physician orders for all discipline visits. G. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. 4. To accurately document visit frequencies and that "0" is not a valid frequency. 5. To obtain physician orders for all</p>	

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			home health visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders , specifically the ordered visit frequencies, to ensure the accurate visit frequencies are documented and physician orders are obtained for any additional visits . The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders until 100% compliance is maintained for a period of 6 months. After that the Agency will continue to audit 10% of all Medical Plans-of- Care and	

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			Physician verbal orders for accurate visit orders and frequencies on an ongoing basis to ensure continued compliance with this requirement. Section 8 (G0334): The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date, including OASIS collection at start of care or within 5 calendar days after the start of care. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS assessments for timeliness of completion until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all	

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			<p>OASIS assessments to ensure continued compliance with this requirement. Section 9 (G0226):</p> <p>A. 1. Agency educated all clinical staff on the policy regarding the administration of medication with specific attention to medicated lotions. A. 2. Agency will ensure continued compliance by unannounced site visits to ensure compliance until 100% compliance is achieved for 6 months, and then ongoing surveillance via unannounced site visits will be conducted to ensure continued compliance with standard. Section 10 (G0229):</p> <p>A. 1. Agency educated all clinical staff regarding standard that all skilled patients receiving home health aide services must have a supervisory visit completed every 14 days. Agency developed a supervisory visit tracking tool to track supervisory visits. A. 2. Agency will audit 100% of all supervisory visits to ensure compliance until 100% compliance is maintained for 6 months and then 10% of supervisory visits will be audited to ensure ongoing compliance with standard. Section 11 (G0121): Agency has educated all staff on the following: 1. Hand Rub Policy and Procedure 2. Hand Washing Policy and Procedure Agency evaluated education using written exam to determine competency regarding hand rub and hand wash policies and procedures. Agency will</p>	

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			ensure compliance with G0121 by unannounced on site visits until 100% compliance is achieved for 6 months. Agency will track this using a hand rub/hand wash evaluation form completed by RN staff. Section 12 (G0141): A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the	

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			<p>correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file.</p> <p>C. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. D.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. D.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact.</p> <p>E. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations</p>	

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			<p>from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. E.2. Agency will ensure compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. Section 13 (G0321): To correct the errors that are on some patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number being reported within the OASIS is <u>8888888888</u>. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone</p>	

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			<p>call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a previous accepted OASIS that was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. The Agency will monitor and review final validation reports and correct errors. The Agency will ensure all OASIS data submitted is not rejected.</p>	

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			<p>The Agency will ensure correction of rejected data. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement.</p> <p>Section 14 (G0322): To correct the errors that are on some patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number being reported within the OASIS is <u>8888888888</u>. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within</p>	

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			<p>the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a previous accepted OASIS that was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what</p>	

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			<p>kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. The Agency will monitor and review final validation reports and correct errors. The Agency will ensure all OASIS data submitted is not rejected. The Agency will ensure correction of rejected data. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. Section 15 (G0324): To correct the errors that are on some</p>	

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			<p>patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number being reported within the OASIS is 8888888888. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the</p>	

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			Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a previous accepted OASIS that was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. The Agency will monitor and review final validation reports and correct errors. The Agency will ensure all OASIS data submitted is not rejected. The Agency will ensure correction of rejected data. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final	

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			validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. Section 16 (G0244): A.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. A. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual meetings thereafter to ensure continued compliance with this requirement. B. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program.	

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G 0141 Bldg. 00	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H); failed to ensure criminal background checks were completed within 3 days of starting patient care for 3 of 6 employee files reviewed (B, H, and G); failed to ensure</p>	G 0141	<p>B.2. Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this requirement. The Administrator is responsible for ongoing compliance with this G0133.</p> <p>A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee</p>	07/06/2016

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	<p>3 of 4 HHAs completed the HHA competency test (E, F, and H); failed to ensure 1 of 2 Registered Nurse (RN) files contained an annual evaluation; and failed to ensure didactic information was separate from medical information for 1 of 6 files reviewed (E).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test, and failed to evidence a criminal background check had been conducted until 6/20/16. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation program required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet,</p>		<p>files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. C. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. D.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation</p>	

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	<p>and the test is probably with other missing items. Employee I stated she ran the background check for employee H on date of hire, but cannot find it. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file B (Alternate Administrator/Nursing Supervisor) was reviewed on 6/20/16. Date of hire and first patient contact dates 12/12/13. The file failed to evidence the criminal background check was sent in until 12/18/13, and failed to evidence annual performance evaluations for 2014 and 2015.</p> <p>A. During interview on 6/20/16 at 10:15 AM, employee I (Office Manager) stated employee B was part time and just hired full time within the last 3 months, so not sure how much she worked prior to that.</p>		<p>were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. D.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact.</p> <p>E. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. E.2. Agency will ensure compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. Administrator will be responsible for ensuring ongoing compliance with G0141.</p>		

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	<p>B. During interview on 6/20/16 at 11:30 AM, the Alternate Administrator stated she was PRN for 2 years and probably only made 2 visits- she does not know that an annual evaluation was completed. She stated she recently took the Alternate Administrator/Nursing Supervisor positions around February of this year.</p> <p>3. Employee file G, RN, was reviewed on 6/20/16. Date of hire 3/10/14, first patient contact date 3/14/14. The file failed to evidence the criminal background check was sent in until 4/29/14.</p> <p>A. During interview on 6/21/16 at 9:10 AM, the Alternate Administrator stated these older criminal checks were in storage, but the Administrator could not locate the original for employee G.</p> <p>4. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>5. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency</p>			

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	<p>test.</p> <p>A. Employee F's medical file contained a Use and disclosure form, and Certificate of Completion for Adult First Aid/CPR [cardiopulmonary resuscitation] and failed to evidence all documents were medical related.</p> <p>B. During interview on 6/20/16 at 9:20 AM, employee I stated those two forms should not be in the medical portion of the file.</p> <p>C. During interview on 6/20/16 at 11:00 AM, the Alternate Administrator stated they do not see a policy for the order of employee files information.</p> <p>6. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure on the part of the employee to provide this document will relieve Home Healthcare Associates of any employment obligations. The employee will be considered unable to perform duties of the job requiring the</p>			

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	<p>documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p> <p>7. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meets the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>8. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <p>9. The agency's policy titled "Employee Background Check," Version 1, reviewed 6/1/15, stated "Pre-Offer Background Check. Before extending an offer of</p>			

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G 0158 Bldg. 00	<p>employment to a job applicant: a. For individuals who have not lived outside of the state of Indiana in the previous two years, HHCA will obtain a copy of the individual's limited criminal history check from the Indiana State Police Repository."</p> <p>10. The agency's policy titled "Performance Evaluations," no number, no date stated "Annual Performance Evaluation for all Employees: This document is completed on the employee's anniversary date for all employees who have successfully completed their first year of employment."</p> <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. Based on document review and interview, the agency's failed to ensure the Registered Nurse completed the start of care as ordered for 1 of 10 records reviewed (#8); failed to ensure missed visits were reported to the physicians for 4 of 10 clinical records reviewed (# 2, 3, 5, and 8); failed to obtain an order for 1 extra HHA visit (#2); and failed to ensure discipline frequencies did not include a</p>	G 0158	A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency scheduling department will actively work to replace employees who "call-off" for their assigned visit. The patient/caregiver will be notified of the call-off and the replacement options. C. The Agency will track all missed visits in the Brightree	07/15/2016

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	<p>frequency of 0 (zero) for 4 of 10 clinical records reviewed (# 3, 4, 6 and 9).</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During interview on 6/16/16 at 3:00 PM, the Nursing Supervisor/Alternate Administrator stated the agency has to enter a 0 for some frequencies which only have a day or two at the beginning of the certification period so that the computer will accept the information for visits, the 0 frequency visit is not a billable visit; and this includes having to enter skilled nurse (SN) visits for Home Health Aide (HHA) supervisory visits even when patients are HHA only. 2. During interview on 6/17/16 at 1:20 PM, the Nursing Supervisor/Alternate Administrator stated the agency does not send missed visit notifications to the physicians if the patient refuses care or has an appointment, but they do for other reasons. The Nursing Supervisor stated the 6/11 miss for patient #2 was a no call no show by the HHA and the agency was not aware until the following day. 3. During interview on 6/17/16 at 1:25 PM, employee I (Office Manager) stated the physician was not notified about patient #2's missed visit from 6/11, that patient lives in a group home and they 		<p>system (EMR) by documenting the missed visits in the Missed Visit Log. D. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. E. The Agency will accurately document each patient's visit frequency on all Plans of Care and the Agency will not utilize "0" as a visit frequency. F. The Agency will obtain physician orders for all discipline visits. G. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. 4. To accurately document visit frequencies and that "0" is not a valid frequency. 5. To obtain physician orders for all home health visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician</p>	

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	<p>group home does not like to give the agency time to find replacement staff.</p> <p>4. During interview on 6/17/16 at 1:35 PM, employee I stated she usually does not put anything in communication notes when there is a missed visit, she just documents the missed visit in the computer with reason for the miss.</p> <p>5. During interview on 6/15/16 at 12:00 PM, the Administrator stated the plan of care summaries are the 60 day summaries which are sent to the physicians with the recertification paper work.</p> <p>6. The agency's policy titled "Missed Visits," no number, no date, stated "Procedure: If the staff member is unable to replaced and the patient's Plan of Care visit frequency is not met, the missed visit will be recorded and the patient's physician will be notified on the next plan of care. If the patient has several missed visits due to staff call off or at patient's request, the physician will be notified immediately either in writing or verbally via telephone and documented as such."</p> <p>7. The clinical record for patient #2 was reviewed on 6/17/16. Start of Care date 3/10/16. The plan of care dated 5/9-7/7/16 contained orders for Aide 6</p>		<p>ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders , specifically the ordered visit frequencies, to ensure the accurate visit frequencies are documented and physician orders are obtained for any additional visits . The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders until 100% compliance is maintained for a period of 6 months. After that the Agency will continue to audit 10% of all Medical Plans-of- Care and Physician verbal orders for accurate visit orders and frequencies on an ongoing basis to ensure continued compliance with this requirement. The Director of Nursing is responsible for ensuring ongoing compliance with G158.</p>	

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	<p>times a week for 1 week, 7 times a week for 7 weeks, and 5 times a week for 1 week. Diagnosis was Profound Intellectual Disability. The record failed to evidence HHA visits were conducted on 5/23, 5/24, 5/28, and 6/11/16. The record failed to evidence an order was obtained for an extra HHA visit the week of 4/7-4/9/16.</p> <p>A. The documents titled "Daily Schedule" for patient #2 dated 5/23, 5/24, 5/28, and 6/11/16 stated "Comments- Staff refused alternate caregiver." These forms failed to evidence the physician was notified of the missed visits for 5/23, 5/24, and 5/28 immediately in writing or verbally via telephone as per agency policy. The 6/11 missed visit form failed to state this was a no call no show by the HHA.</p> <p>8. The clinical record for patient # 3 was reviewed on 6/17/16. Start of care date 12/19/13. The plan of care dated 4/7-6/5/16 contained orders for SN every 30 days for 60 days with 2 PRN for supervision of HHA, change in condition and recertification; and beginning 4/7/15 HHA 2 times a week for 1 week, 6 times a week for 8 weeks, and 0 times a week for 1 week. The last week of the certification period started 6/5/16, the frequency should have included HHA 1</p>			

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	<p>time for 1 week. The record evidenced 3 visits were conducted by the HHA, and failed to evidence the physician was notified of 4 missed visits.</p> <p>A. During interview on 6/15/16, the Nursing Supervisor stated 6/5 should have been listed as 1 time a week for 1 week.</p> <p>B. The record evidenced HHA services were provided 3 times in the first week of care on 4/7, 4/8, and 4/9/16. The agency failed to follow the frequency ordered, and failed to obtain an order for this extra visit.</p> <p>C. The record evidenced 4 missed HHA visits on 4/23, 5/14, 5/15, and 6/3/16; the "Daily Schedule" note for patient #8 dated 4/23 stated "Staff declined alt aide and time;" the "Daily Schedule" note dated 5/14 and 5/15/16 stated "Staff refused alternate time or caregiver;" the "Daily Schedule" note dated 6/3/16 stated "Staff refused alternate time."</p> <p>D. During interview on 6/17/16 at 2:30 PM, employee I stated the physician was not notified of the missed visits for patient #3 and on 5/14 and 5/15 the assigned HHA was in the hospital and the group home said it was okay to not send</p>			

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	<p>other staff.</p> <p>9. The clinical record for patient # 4 was reviewed on 6/20/16. Start of care 2/9/16. The plan of care dated 4/9-6/7/16 contained orders for Aide 0 times a week fro 1 week, 5 times a week for 8 weeks and 2 times a week for 1 week. The frequency for the first week should not have been 0.</p> <p>10. The clinical record for patient # 5 was reviewed on 6/20/16. Start of care 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for SN 30 days for 60 days and 2 PRN for change in condition, HHA supervision and recertification in last 5 days of certification period; and beginning on 5/8/16, Aide 5-10 times a week for 8 weeks, 3-6 times a week for 1 week, each visit up to 10 hours total, may do multiple visits a day as needed to accommodate patients outside appointments. The record failed to evidence the physician was notified of a missed visit on 5/30/16.</p> <p>A. The record evidenced a missed HHA visit on 5/30/16.</p> <p>B. During interview on 6/20/16 at 2:45 PM, the Nursing Supervisor stated she does not see documentation of a</p>			

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	<p>reason for the 5/30 missed visit, and the physician was not notified.</p> <p>11. The clinical record for patient # 6 was reviewed on 6/15/16. The plan of care dated 4/16-6/14/16 contained orders for Skilled Nurse (SN) 0 times a week for 1 week; 3 times a week for 8 weeks; and 1 time a week for 3 weeks; and HHA 1 time a week for 1 week, 7 times a week for 8 weeks, and 3 times a week for 1 week. The record failed to evidence a SN frequency other than 0 for week 1.</p> <p>12. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification; beginning week of 4/12/16 SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the physician was notified of a missed SN visit the week of 5/15-5/21/16, and the record failed to evidence the SN assess and evaluate was completed per date physician ordered.</p> <p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p>			

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G 0170	<p>B. The record failed to evidence a SN visit was conducted the week of 5/15-5/21/16.</p> <p>C. During interview on 6/17/16 at 10:30 AM, the Nursing Supervisor stated she could not find a reason for the missed visit the week of 5/15-/521, and there are not any notes in the computer stating a visit was missed.</p> <p>D. The Plan of Care Summary dated certification end 6/6/2016 failed to evidence an missed visits were reported to the physician.</p> <p>E. The Skilled Nurse Visit Note dated 5/4/16 stated "Anticipated next visit scheduled: 05/17/2016.</p> <p>13. The agency's policy titled "Plan of Care," no number, no date, stated "The Nursing Plan of Care must contain the following: ... The frequency and duration of visits."</p>			
	484.30 SKILLED NURSING SERVICES			

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Bldg. 00	<p>The HHA furnishes skilled nursing services in accordance with the plan of care. Based on document review and interview, the agency failed to ensure the Registered Nurse completed the initial assessment/start of care within the date range ordered by the physician for 1 of 10 clinical records reviewed (#10).</p> <p>Findings include</p> <p>1. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification beginning week of 4/12/16; SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the physician was notified of a missed SN visit the week of 5/15-5/21/16, and the record failed to evidence the SN assess and evaluate was completed per date physician ordered.</p> <p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p> <p>B. The record failed to evidence a SN visit was conducted the week of</p>	G 0170	<p>A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. C. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. D. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to</p>	07/15/2016
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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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G 0176	<p>5/15-5/21/16.</p> <p>C. During interview on 6/17/16 at 10:30 AM, the Nursing Supervisor stated she could not find a reason for the missed visit the week of 5/15-/521, and there are not any notes in the computer stating a visit was missed.</p> <p>D. The Plan of Care Summary dated certification end 6/6/2016 failed to evidence an missed visits were reported to the physician.</p> <p>E. The Skilled Nurse Visit Note dated 5/4/16 stated "Anticipated next visit scheduled: 05/17/2016.</p> <p>2. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Initial Assessment: A registered nurse will conduct an initial assessment visit to determine the immediate care and support needs of the patient and eligibility. This initial assessment visit will be within 48 hours of the referral or within 48 hours of the patient's return home or as ordered by the physician. If the visit can not be made within the required 48 hours, the reason for such must be documented."</p>		<p>audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. Director of Nursing will be responsible for ongoing compliance with G0170.</p>	
	484.30(a)			

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Bldg. 00	<p>DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care provided for 2 of 4 discharge records reviewed (# 9, and 10); failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (# 9); and failed to ensure RNs documented visits timely for 3 of 10 clinical records reviewed (# 4, 5, and 6).</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency's policy titled "Documentation Standards and Guidelines," no number, no date, stated "Procedure: ... 2. Current: Timely documentation, as near to the time of occurrence as feasible. Entire are always dated when they were made, i.e. no backdating." 2. The agency's policy titled "Electronic Charting," no number, no date, stated "Staff must document prior to leaving clients home and have documentation in "ready to review" status within 24 hours. 	G 0176	<p>A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. B. 1a. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. B. 1b. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in</p>	07/15/2016

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	<p>... Nursing staff will have the ability to electronically chart in the home. It is expected that all documentation be completed prior to leaving the client's home at the end of the shift.</p> <p>Documentation will be reviewed by an Administrative RN and will be "rejected" to the documenting field nurse as needed for correction. The filed nurse will then have 24 hours to correct and resubmit any documentation."</p> <p>3. The clinical record for patient # 4 was reviewed on 6/20/16. Start of care date 2/9/16. The initial start of care assessment completed by employee C, RN, failed to evidence it was electronically signed until 2/18/16, 9 days post start of care.</p> <p>A. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>*** The clinical record for patient # 5 was reviewed on 6/20/16. Start of care date 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for HHA services. The record failed to evidence the electronic RN visit notes were completed in a timely manner.</p>		<p>ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this requirement. Administrator will be responsible for ongoing compliance for standard G0176.</p>	

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	<p>A. The electronic recertification visit note dated 5/5/15 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>4. The clinical record for patient # 6 was reviewed on 6/15/16. Start of care date 12/28/13. The record failed to evidence timely submission of electronic visit notes.</p> <p>A. The SN visit dated 5/6/16 by employee G (RN) was not signed until 6/7/16.</p> <p>B. The SN visit dated 5/27/16 by employee G was not signed until 6/7/16.</p> <p>5. The clinical record for patient # 9 was reviewed on 6/17/16. Start of care date 12/9/13. The patient was discharged on 1/5/16 to long term care. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary was not completed until 3/2/16, and failed to include a summary of care provided.</p> <p>A. During interview on 6/16/16 at 12:30 PM, the Nursing Supervisor stated she was not here at that time, so she is not sure why the discharge summary for patient #9 was not completed until March, but the discharge summaries are</p>			

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G 0202 Bldg. 00	<p>to include a summary of care provided, per agency policy.</p> <p>6. The clinical record for patient # 10 was reviewed on 6/16/17. Start of care 12/6/13. The patient was discharged to home per patient and care giver request on 2/2/16. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary failed to include a summary of care provided.</p> <p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry; failed to ensure 3 of 4 HHA files contained a copy of the HHA competency test (See G 203, G 211, G 212, and G 221); failed to ensure the Registered Nurse supervised the HHA to ensure they did not administer a prescription medication in 1 of 5 home visits of HHA observations (See G 226); and failed to ensure the supervision of HHA every 2 weeks for 1 of 2 records reviewed of patients receiving HHA and skilled services (See G 229).</p> <p>The cumulative effect of this systemic</p>	G 0202	<p>A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written</p>	07/15/2016

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	problem resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide.		competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency educated all clinical staff on the policy regarding the administration of medication with specific attention to medicated lotions. C 2. Agency will ensure continued compliance by unannounced site visits to ensure compliance until 100% compliance is achieved for 6 months, and then ongoing surveillance via unannounced site visits will be conducted to ensure continued compliance with standard. D. 1. Agency educated all clinical staff regarding standard that all skilled patients receiving home health aide services must have a supervisory visit completed every 14 days. Agency developed a supervisory visit tracking tool to track supervisory visits. D. 2. Agency will audit 100% of all supervisory visits to ensure compliance until 100% compliance is maintained for 6 months and then 10% of supervisory visits will be audited	

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G 0203 Bldg. 00	<p>484.36(a) HOME HEALTH AIDE SERVICES Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in §484.4 for "home health aide".</p> <p>Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H); failed to ensure 3 of 4 HHA files contained a copy of the HHA competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry</p>	G 0203	<p>to ensure ongoing compliance with standard. Administrator will be responsible for the above.</p> <p>A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home</p>	07/15/2016

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	<p>Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency</p>		<p>Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. Administrator will be responsible for the above.</p>	

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	<p>test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure o the part of the employee to provide this document will relive Home Healthcare Associates of any employment obligations. The employee will be considered unable to perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p>			

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G 0211 Bldg. 00	<p>5. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meet the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>6. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H) prior to providing care to patients, and failed to ensure 3 of 4 HHA files contained a copy</p>	G 0211	<p>A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance</p>	07/15/2016

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	<p>of the HHA competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at</p>		<p>has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. Administrator will be responsible for the above.</p>	

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	<p>11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure o the part of the employee to provide this document will relive Home Healthcare Associates of any employment obligations. The</p>			

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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G 0212 Bldg. 00	<p>employee will be considered unable to perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p> <p>5. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meet the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the</p>			

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	<p>individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on document review and interview the agency failed to failed to ensure 3 of 4 HHA files contained a copy of the HHA competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA competency test.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency</p>	G 0212	<p>A.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. A.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. Administrator will be responsible for the above.</p>	07/15/2016

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	<p>test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure o the part of the employee to provide this document will relive Home Healthcare Associates of any employment obligations. The employee will be considered unable to perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p>			

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G 0221 Bldg. 00	<p>5. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meet the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>6. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <p>484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must maintain documentation which demonstrates that the requirements of this standard are met. Based on document review and interview the agency failed to ensure 3 of 4 HHA files contained a copy of the HHA competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on</p>	G 0221	A.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current	07/15/2016

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	<p>6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced</p>		<p>employees were found to have current HHA written examination results in their employee file. A.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. Administrator is responsible for ensuring ongoing compliance with G0221.</p>	

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G 0226 Bldg. 00	<p>employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered. Based on observation, document review,</p>	G 0226	A. 1. Agency educated all clinical	07/15/2016

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	<p>and interview, the agency failed to ensure the Registered Nurse supervised the home health aide (HHA) to ensure they did not administer a prescription medication in 1 of 5 home visits of HHA observations. (# 3)</p> <p>Findings include</p> <p>1. During home visit observation on 6/16/16 at 12:30 PM, employee E (HHA) was observed providing care to patient # 3. Employee E was observed applying Lac-Hydrin 12% lotion to the patient's back, and legs. The bottle contained a prescription label which read "Lac-Hydrin 12 % Ammonium Lactate, daily to dry skin and PRN (as needed)." Patient # 3 lives in a group home.</p> <p>A. The plan of care dated 6/6-8/4/16 contained diagnoses of Profound Intellectual Disabilities and Cerebral Palsy. The medication section listed the lotion: Lac-Hydrin 12 % topical apply to dry skin daily as needed."</p> <p>B. The Home Health Aide Care plan printed 6/14/16 failed to evidence medication assistance was tasked for the HHA.</p> <p>C. During interview on 6/16/16 at 2:40 PM, employee B (Nursing</p>		<p>staff on the policy regarding the administration of medication with specific attention to medicated lotions. A. 2. Agency will ensure continued compliance by unannounced site visits to ensure compliance until 100% compliance is achieved for 6 months, and then ongoing surveillance via unannounced site visits will be conducted to ensure continued compliance with standard. Director of Nursing will be responsible for ongoing compliance with standard G0226.</p>	

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	<p>Supervisor/Alternate Administrator) stated if a HHA is checked off for medication assistance, they are allowed to assist with self-application, and the agency's consultant told us if it's on the medication list and part of personal care, the HHA can apply it. The Nursing Supervisor stated otherwise the group home staff need to do it.</p> <p>2. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "The Home Health Aide (HHA) will only provide services within their designated scope of practice."</p> <p>3. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Essential Duties and Responsibilities: ... Reminds client to take prescribed medications as direct by physician or home care nurse."</p> <p>4. The agency's policy titled "Medication assistance by HHA/Attendant Caregivers," no number, no date, stated "Medication assistance means "the provision of assistance through reminders or cues to take the medication, the opening of pre-set medication containers, and providing assistance in the handling or ingesting of non-controlled substance medications, including ...</p>			

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G 0229 Bldg. 00	<p>over-the-counter medications; and to an individual who is unable to accomplish the task due to an impairment and who is either competent and has directed the services or is incompetent and has the services directly by a competent individual who may consent it health care for the impaired individual." Procedures: Home Health Aides ... may assist patients with medication in the manner listed above as instructed by the Supervising Nurse."</p> <p>484.36(d)(2) SUPERVISION 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. Based on document review and interview, the agency failed to ensure the supervision of Home Health Aides (HHA) every 2 weeks for 1 of 2 records reviewed of patients receiving HHA and skilled services. (#6)</p> <p>Findings include</p> <p>1. The clinical record for patient # 6 was reviewed on 6/15/16. The plan of care dated 4/16-6/14/16 contained orders for Skilled Nurse (SN) 0 times a week for 1 week; 3 times a week for 8 weeks; and 1</p>	G 0229	A. 1. Agency educated all clinical staff regarding standard that all skilled patients receiving home health aide services must have a supervisory visit completed every 14 days. Agency developed a supervisory visit tracking tool to track supervisory visits. A. 2. Agency will audit 100% of all supervisory visits to ensure compliance until 100% compliance is maintained for 6 months and then 10% of supervisory visits will be audited to ensure ongoing compliance with standard. Director of Nursing will be responsible for	07/15/2016

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G 0235 Bldg. 00	<p>time a week for 3 weeks; and HHA 1 time a week for 1 week, 7 times a week for 8 weeks, and 3 times a week for 1 week. The record failed to evidence HHA supervisory visits were completed every 14 days.</p> <p>A. The previous HHA supervisory visit was conducted with the recertification SN visit on 4/11/16. The record failed to evidence another HHA supervisory visit was conducted until 5/6/16, 25 days later.</p> <p>B. The record failed to evidence another HHA supervisory visit was not conducted until 5/27/16, 21 days later.</p> <p>C. During interview on 6/15/16 at 12:35 PM, the Nursing Supervisor stated she did not see anymore HHA supervisory visits documented by the nurse, so they were missed.</p> <p>2. The agency's policy titled "Certified Hoe Health Aide Services/Supervision," no number, no date, stated "Supervisory Practice: If the patient receives skilled nursing care, the registered nurse will perform the supervisory visit no less than every 2 weeks."</p> <p>484.48 CLINICAL RECORDS</p>		ongoing compliance with G0229.	

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	<p>Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care provided for 2 of 4 discharge records reviewed; failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (See G 303); and failed to ensure Home Health Aides (HHA) and RNs completed visit notes in a timely manner and according to agency policy for 8 of 10 clinical records reviewed; failed to ensure consent for services was signed prior to providing care for 1 of 10 clinical records reviewed; and failed to ensure the Registered Nurse collected Outcome Assessment and Information Set data on start of care and failed to ensure the information was completed within 5 days of start of care for 1 of 4 records reviewed of patients receiving skilled services (See G 236).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.</p>	G 0235	<p>A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. A. 2. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. B.1a. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. B.1b. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. B. 2. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this requirement. C. 1. Agency audited charts for</p>	07/15/2016	

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G 0236 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care provided for 2 of 4 discharge records reviewed (# 9, and 10); failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (# 9); failed</p>	G 0236	<p>compliance with OASIS completion during initial admission visit. All skilled patients have OASIS completed. C. 2. Agency will ensure compliance by auditing 100% of OASIS for new admissions to ensure OASIS is completed, locked, and transmitted until 100% compliance is maintained for 6 months and then Agency will audit 10% of OASIS to ensure continued compliance. Director of Nursing will be responsible for the continued compliance with G0235.</p> <p>A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. A. 2. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the</p>	07/15/2016

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	<p>to ensure Home Health Aides (HHA) and RNs completed visit notes in a timely manner and according to agency policy for 8 of 10 clinical records reviewed (# 2, 3, 4, 5, 6, 8, 9 and 10); failed to ensure consent for services was signed prior to providing care for 1 of 10 clinical records reviewed (# 7); and failed to ensure the Registered Nurse collected Outcome Assessment and Information Set (OASIS) data on start of care and failed to ensure the information was completed within 5 days of start of care for 1 of 4 records reviewed of patients receiving skilled services. (#8)</p> <p>Findings include</p> <p>1. The agency's policy titled "Documentation Standards and Guidelines," no number, no date, stated "Procedure: ... 2. Current: Timely documentation, as near to the time of occurrence as feasible. Entries are always dated when they were made, i.e. no backdating."</p> <p>2. The agency's policy titled "Electronic Charting," no number, no date, stated "Staff must document prior to leaving clients home and have documentation in "ready to review" status within 24 hours. ... Nursing staff will have the ability to electronically chart in the home. It is</p>		<p>Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. B.1. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. B. 2. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this standard. C. 1. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. C. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all</p>	

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	<p>expected that all documentation be completed prior to leaving the client's home at the end of the shift. Documentation will be reviewed by an Administrative RN and will be "rejected" to the documenting field nurse as needed for correction. The filed nurse will then have 24 hours to correct and resubmit any documentation."</p> <p>3. The agency's policy titled "Patient Discharge (Summary)," no number, no date, stated "All patient discharge summaries must be complete within 30 days of discharge. ... The discharge summary should include: ... Summary of care provided ... The discharge summary and other relevant clinical record documents will be completed and submitted to the organization within seven days of discharge from the agency. ... The agency will complete all necessary audits to determine the completeness of the patient's clinical record within thirty days of the last home visit and discharge date."</p> <p>4. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p>		<p>patient charts to determine ongoing compliance with standard. D. 1. Agency audited 100% of patient charts to determine the presence of Start of Care(SOC) OASIS. A SOC OASIS is found on 100% of current skilled patient charts. D.2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. E. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. E. 2. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this standard. Director of Nursing will be responsible for the ongoing compliance with standard G0236.</p>		

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	<p>5. The clinical record for patient # 2 was reviewed on 6/17/16. Start of care date 3/10/16. The plan of care dated 5/9-7/7/16 contained orders for HHA services. The record failed to evidence the electronic HHA visit notes were completed in a timely manner.</p> <p>A. The electronic HHA Visit Note dated 5/29/16 by employee J (HHA) was not signed until 6/15/16, 17 days after the visit.</p> <p>B. The electronic HHA Visit Note dated 5/30 by employee K (HHA) was not signed until 6/15/16, 16 days after the visit.</p> <p>C. The electronic HHA Visit Note dated 5/13 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>D. The electronic HHA Visit Note dated 5/11 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>E. The electronic HHA Visit Note dated 5/9 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>F. The electronic HHA Visit Note dated 5/6 by employee K was not signed until 6/15/16, over 30 days after the visit.</p>			

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	<p>G. The electronic HHA Visit Note dated 5/4 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>H. During interview on 6/17/16 at 1:25 PM, the Nursing Supervisor stated employee K is out of compliance with documentation, that aide is not the only one, but the agency has not had a chance to talk with employee K about this as she is not returning their phone calls. The Nursing Supervisor stated the agency has been short staffed and not been able to properly provide for discipline and corrections.</p> <p>I. During interview on 6/17/16 at 1:25 PM, employee I (Office Manager) stated employee K is off the schedule.</p> <p>6. The clinical record for patient # 3 was reviewed on 6/17/16. Start of care 12/19/13. The plan of care dated 4/7-6/5/16 contained orders for HHA services. The record failed to evidence the electronic HHA visit notes were completed in a timely manner.</p> <p>A. The electronic HHA Visit Note dated 4/9/16 by employee K was not signed until 4/19/16, over 10 days after the visit.</p> <p>7. The clinical record for patient # 4 was</p>			

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	<p>reviewed on 6/20/16. Start of care date 2/9/16. The plan of care dated 4/9-6/7/16 contained orders for HHA services. The record failed to evidence the electronic HHA notes and RN visit notes were completed in a timely manner.</p> <p>A. The initial start of care assessment completed by employee C, RN, failed to evidence it was electronically signed until 2/18/16, 9 days post start of care.</p> <p>B. The electronic HHA note dated 6/2/16 by employee L (HHA) was not signed until 6/12/16, 10 days after the visit.</p> <p>C. The electronic HHA note dated 5/31/16 by employee L was not signed until 6/6/16, 6 days after the visit.</p> <p>D. The electronic HHA note dated 5/19/16 by employee L was not signed until 5/25/16, 5 days after the visit.</p> <p>E. The electronic HHA note dated 5/18/16 by employee L was not signed until 5/25/16, 7 days after the visit.</p> <p>F. The electronic HHA note dated 5/17/16 by employee L was not signed until 5/25/16, 8 days after the visit.</p> <p>G. The electronic HHA note dated</p>			

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	<p>5/10/16 by employee L was not signed until 5/15/16, 5 days after the visit.</p> <p>H. The electronic HHA note dated 5/9/16 by M (HHA) was not signed until 5/16/16, 7 days after the visit.</p> <p>I. The electronic HHA note dated 5/5/16 by employee L was not signed until 5/15/16, 10 days after the visit.</p> <p>J. The electronic HHA note dated 5/4/16 by employee L was not signed until 5/15/16, 11 days after the visit.</p> <p>K. The electronic HHA note dated 5/3/16 by employee L was not signed until 5/15/16, 12 days after the visit.</p> <p>L. The electronic HHA note dated 4/22/16 by employee N (HHA) was not signed until 4/28/16, 6 days after the visit.</p> <p>M. The electronic HHA note dated 4/21/16 by employee N was not signed until 4/28/16, 7 days after the visit.</p> <p>8. The clinical record for patient # 5 was reviewed on 6/20/16. Start of care date 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for HHA services. The record failed to evidence the electronic HHA and RN visit notes</p>			

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	<p>were completed in a timely manner.</p> <p>A. The electronic recertification visit note dated 5/5/15 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>B. The electronic HHA note dated 5/10/16 by employee O (HHA) was not signed until 5/14/16, 4 days after the visit.</p> <p>C. The electronic HHA note dated 5/12/16 by employee P (HHA) was not signed until 5/16/16, 6 days after the visit.</p> <p>D. The electronic HHA note dated 5/13/16 by employee P was not signed until 5/16/16, 3 days after the visit.</p> <p>E. The electronic HHA note dated 5/19/16 by employee P was not signed until 5/24/16, 5 days after the visit.</p> <p>F. The electronic HHA note dated 5/20/16 by employee P was not signed until 5/24/16, 4 days after the visit.</p> <p>G. The electronic HHA note dated 5/27/16 by employee P was not signed until 5/31/16, 4 days after the visit.</p> <p>H. The electronic HHA note dated 5/30/16 by employee O, a missed visit,</p>			

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	<p>was not signed until 6/15/16, 16 days post missed visit.</p> <p>I. The electronic HHA note dated 6/3/16 by employee P was not signed until 6/8/16, 5 days after the visit.</p> <p>J. The electronic HHA note dated 6/2/16 by employee P was not signed until 6/8/16, 6 days after the visit.</p> <p>9. The clinical record for patient # 6 was reviewed on 6/15/16. Start of care date 12/28/13. The record failed to evidence timely submission of electronic visit notes.</p> <p>A. The SN visit dated 5/6/16 by employee G (RN) was not signed until 6/7/16.</p> <p>B. The SN visit dated 5/27/16 by employee G was not signed until 6/7/16.</p> <p>10. The clinical record for patient #7 was reviewed on 6/17/16. Start of care date 9/22/14. The record failed to evidence the patient had signed a consent for services form and failed to evidence the agency retained notification of patient rights for this admission.</p> <p>A. During interview on 6/17/16, at 11:30 AM, the Alternate Administrator</p>			

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	<p>stated she could not find the consent for services for 9/22/14.</p> <p>11. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification; beginning week of 4/12/16 SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the electronic RN and HHA visit notes were completed in a timely manner, and failed to evidence the RN collected OASIS data on admission or within 5 days of start of care.</p> <p>A. The Initial Evaluation RN visit note dated 4/11/16 by employee C failed to evidence the initial start of care assessment included OASIS data, and failed to evidence a reason the visit was not completed until 4/11/16. Employee C failed to electronically sign this document until 4/15/16, 4 days after the visit.</p> <p>B. The SN Visit note dated 5/4/16 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>C. During interview on 6/17/16 at 10:10 AM, the Nursing Supervisor stated</p>			

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	<p>the start of care OASIS information is not showing up in the computer, but there is not a way to do any other OASIS assessments without one in the computer. The Nursing Supervisor stated there is not a reason in the computer as to why the RN did not assess for start of care until 4/11/16.</p> <p>12. The clinical record for patient # 9 was reviewed on 6/17/16. Start of care date 12/9/13. Discharge date 1/5/16 to long term care. The Discharge Summary was not completed until 3/2/16 and failed to include a summary of care provided. The Discharge Summary section titled "Summary/Notes" is blank.</p> <p>A. The Discharge Summary section titled "Summary/Notes" is blank.</p> <p>B. During interview on 6/16/16 at 12:30 PM, the Nursing Supervisor stated she was not here at that time, so she is not sure why the discharge summary for patient #9 was not completed until March, but the discharge summaries are to include a summary of care provided, per agency policy.</p> <p>13. The clinical record for patient # 10 was reviewed on 6/16/17. Start of care 12/6/13. The patient was discharged to home per patient and care giver request</p>			

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G 0244 Bldg. 00	<p>on 2/2/16. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary failed to include a summary of care provided.</p> <p>14. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Home Healthcare Associates will comply with State and federal guidelines with regards to OASIS data collection and reporting. ... Comprehensive Assessment: (to include the administration of the OASIS) Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status ... This assessment (start of care) will be completed by a registered nurse in a timely manner, consistent with patient's immediate needs, but no later than 5 calendar days from the start of care. ... The Comprehensive Assessment will incorporate the use of current OASIS items."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. Based on document review and</p>	G 0244	A.1. Governing Body met on 7/11/2016 to adopt plan to review	07/15/2016

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	<p>interview, the agency's failed to ensure the annual evaluation conducted in November 2015 included oversight of Outcome Assessment and Information Set (OASIS) data final validation reports and possible error correction for 1 of 1 agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The Governing Body board meeting dated 2/15/16 failed to include employee file review, and OASIS review. 2. During interview on 6/14/15 at 10:35 AM, the Administrator stated the agency does do look back evaluations of OASIS data to make sure they get the same scores as the assessments by the nurses. 3. During interview on 6/15/16 at 10:20 AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving 		<p>dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. A. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual meetings thereafter to ensure continued compliance with this requirement. B. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program. B.2. Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending</p>	

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	<p>them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>4. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible records have been submitted, and all patients are Medicaid patients.</p> <p>5. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not</p>		of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0244.		

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G 0303 Bldg. 00	<p>aware of the location of the submission report.</p> <p>6. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p> <p>484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care</p>	G 0303	<p>A. 1. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. A. 2. The Agency will audit 100% of</p>	07/15/2016

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	<p>provided for 2 of 4 discharge records reviewed (# 9, and 10), and failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (# 9).</p> <p>Findings include</p> <ol style="list-style-type: none"> The agency's policy titled "Documentation Standards and Guidelines," no number, no date, stated "Procedure: ... 2. Current: Timely documentation, as near to the time of occurrence as feasible. Entire are always dated when they were made, i.e. no backdating." The agency's policy titled "Electronic Charting," no number, no date, stated "Staff must document prior to leaving clients home and have documentation in "ready to review" status within 24 hours. ... Nursing staff will have the ability to electronically chart in the home. It is expected that all documentation be completed prior to leaving the client's home at the end of the shift. Documentation will be reviewed by an Administrative RN and will be "rejected" to the documenting field nurse as needed for correction. The filed nurse will then have 24 hours to correct and resubmit any documentation." 		<p>discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. Director of Nursing is responsible for ensuring ongoing compliance with G0303.</p>	

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	<p>3. The agency's policy titled "Patient Discharge (Summary)," no number, no date, stated "All patient discharge summaries must be complete within 30 days of discharge. ... The discharge summary should include: ... Summary of care prided ... The discharge summary and other relevant clinical record documents will be completed and submitted to the organization within seven days of discharge from the agency. ... The agency will complete all necessary audits to determine the completeness of the patient's clinical record within thirty days of the last home visit and discharge date."</p> <p>4. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>5. The clinical record for patient # 9 was reviewed on 6/17/16. Start of care date 12/9/13. The patient was discharged on 1/5/16 to long term care. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary was not completed until 3/2/16, and failed to include a summary of care provided.</p>			

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G 0320 Bldg. 00	<p>A. During interview on 6/16/16 at 12:30 PM, the Nursing Supervisor stated she was not here at that time, so she is not sure why the discharge summary for patient #9 was not completed until March, but the discharge summaries are to include a summary of care provided, per agency policy.</p> <p>6. The clinical record for patient # 10 was reviewed on 6/16/17. Start of care 12/6/13. The patient was discharged to home per patient and care giver request on 2/2/16. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary failed to include a summary of care provided.</p> <p>484.20 REPORTING OASIS INFORMATION HHAs must electronically report all OASIS data collected in accordance with §484.55 Based on document review and interview, the agency failed to ensure Outcome Assessment Information Set (OASIS) data had been transmitted to the state agency monthly and within 30 days after the assessment was completed for 7 of 7 patients whose OASIS data should have been transmitted (See G 321); failed to ensure the accuracy of OASIS data for 7 of 7 patients whose OASIS data should</p>	G 0320	<p>A. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. B. The Agency will monitor and review final validation reports and correct errors. C. The Agency will ensure all OASIS data submitted is not rejected. D. The Agency will ensure correction of rejected data. E. The Agency will ensure error reports are</p>	07/15/2016

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G 0321 Bldg. 00	<p>have been transmitted, and failed to monitor and review final validation reports and correct errors (See G 322); failed to ensure all OASIS data submitted was not rejected; failed to ensure the monitoring of error reports, and failed to ensure the correction of rejected OASIS data for 1 of 1 agency (See G 324).</p> <p>The cumulative effects of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.20 Reporting OASIS.</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on document review and interview, the agency failed to ensure Outcome Assessment Information Set (OASIS) data had been transmitted to the state agency monthly and within 30 days after the assessment was completed for 7 of 7 patients whose OASIS data should</p>	G 0321	<p>monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0320.</p> <p>A. 1. To correct the errors that are on some patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. A. 2. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number</p>	07/15/2016

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	<p>have been transmitted. (# 6, 7, 8, 11, 12, 13 and 17)</p> <p>Findings include</p> <p>1. The Indiana State Department of Health CASPER report dated 12/01/2015-05/31/2016 evidenced the agency failed to submit information monthly, and evidenced the agency failed to submit OASIS information for December 2015, January 2016, February 2016, and April 2016.</p> <p>A. The ISDH CASPER Report for Home Health Agency (HHA) Activity dated 12/01/2015 thru 05/31/2015 stated "No Data Returned for Selected Criteria."</p> <p>B. The ISDH CASPER Report fro HHA Submission Statistics by Agency dated 12/31/2015 thru 05/31/2016 evidenced the agency submitted on 03/15/3016 at 13:40:30 83 records with 100% rejected, and at 13:41:03 5 records with 100 % rejected; and on 05/10/2016 at 13:53:01 5 records with 100 % rejected, and at 13:53:10 5 records with 100 % rejected.</p> <p>C. The ISDH CASPER Report for HHA Error Summary by Agency dated 12/2015 thru 05/2016 evidenced multiple errors including Incorrect Format,</p>		<p>being reported within the OASIS is <u>8888888888</u>. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. A. 3. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a</p>	

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	<p>Incorrect CCN, Inconsistent Dates, Records Submitted Late, Incorrect Format, Inconsistent Record Sequence, Patient Information Mismatch, and Record Timing Invalid.</p> <p>2. On 6/15/16, The agency provided The Centers for Medicare & Medicaid Services (CMS) Submission Report OASIS Agency Final Validation Report dated 03/15/2016 at 13:41:03 stated "# Records Processed: 5, # Production Records Accepted: 0; # Production Records Rejects: 5."</p> <p>A. This report failed to list survey patient #6 (start of care date 12/28/13). Patient #6 had a recertification assessment dated 2/11-2/15/16, which should have been reported in March. This report failed to reflect patient #6 February recertification was submitted.</p> <p>B. This report listed survey patient # 7 (start of care date 9/22/14). The report stated "M0090 Date: 01/13/2016 and Type of Transaction: NEW RECORD ... Date Submitted: 8888888888, Message Number/Severity: -5280 FATAL." This should have been labeled as a recertification, not a new record.</p> <p>C. The report listed survey patient #8 (start of care date 4/8/16). The report</p>		<p>previous accepted OASIS that was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. B. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. C. The Agency will monitor and review final validation reports and correct errors. D. The Agency will ensure all OASIS data submitted is not rejected. E. The Agency will ensure correction of rejected data. F. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100%</p>	

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	<p>stated "M0090 Date: 03/01/2016 ... NEW RECORD ." The OASIS cannot be collected prior to the start of care date, the clinical record evidenced the referral was not made to the agency until 4/8/16.</p> <p>D. The report listed survey patient # 11 (start of care date 6/10/15). The report stated "M0090 Date: 01/04/2016 ... Type of Transaction: NEW RECORD ... Message: Record Submitted Late: The submission date is more than 30 days after M0090 on this new record." The clinical record for patient # 11 evidenced the most recent recertification prior to 1/4/16 was completed on 12/2/2015. This submission was over 30 days late and was not a new record.</p> <p>1. The next recertification for patient #11 was completed on 2/1/16, and should have been submitted within 30 days.</p> <p>E. The report listed survey patient # 12 (start of care date 7/4/14). The report stated "M0090 Date 12/22/2015 ... NEW RECORD ." The submission is over 30 days late, and was not a new record.</p> <p>1. The clinical record for patient #12 evidenced 12/22/2015 was a recertification and should have been submitted in January.</p>		<p>compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0321.</p>	

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	<p>F. This report listed survey patient # 17 (discharged 2/26/16). The report stated "M0090 Date: 02/29/2016 and Type of Transaction: NEW RECORD ... Date Submitted: 8888888888, Message Number/Severity: -5280 FATAL ... OASIS Item(s): M0010_CCN, Stored Value ... Message: Incorrect CCN: M0010 does not match the CMS Certification Number (CCN) in the QIES ASAP System database for the agency identified in the file." This record was a discharge, not a new record.</p> <p>2. On 6/15/16 the agency provided The CMS Submission Report OASIS Agency Final Validation Report dated 3/15/2016 at 13:40:30. This report stated "# Records Process: 83 ... # Production Records Accepted: 0 ... # Production Records Rejected: 83."</p> <p>A. The report listed survey patient # 13 (start of care date 10/23/14). The report stated "M0090 Date: 6/19/15 ... NEW RECORD;" and "M0090 Date: 08/13/2015 ... NEW RECORD;" and "M0090 Date: 10/16/2015 ... NEW RECORD." These submissions would not have been new records.</p> <p>B. This patient (#13) record evidenced recertifications were completed on 12/16/15 and 2/10/2016</p>			

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	<p>and 4/14/16. The 12/16/15 recertification should have been submitted in January, and the 2/10/16 recertification should have been submitted in March. No information was provided for May 2016 submissions.</p> <p>3. The agency submitted two documents titled "OASIS File Submission" dated 3/15/2016 at 13:41:03, and 05/10/2016 at 13:53:10. Both documents stated "Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports."</p> <p>4. On 6/14/16 at 10:25 AM, the January OASIS File Submission Report and Final Validation Report was requested. As of 6/21/16 at 11:30 AM, these documents had not been provided.</p> <p>5. During interview on 6/15/16 at 10:20 AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The</p>			

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	<p>Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>6. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency, and they will have to start printing them again, but all OASIS eligible records have been submitted, and all patients are Medicaid patients.</p> <p>7. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their</p>			

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G 0322 Bldg. 00	<p>submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not aware of the location of the submission report.</p> <p>8. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Procedure: HHA will encode and electronically transmit each completed OASIS assessment to the State agency's or the CMS OASIS contractor, regarding the beneficiary with respect to which such information is required to be transmitted within 30 days of completing the assessment of the beneficiary."</p> <p>484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on document review and interview, the agency failed to ensure the accuracy of Outcome Assessment Information Set (OASIS) data for 7 of 7 patients whose OASIS data should have been transmitted (# 6, 7, 8, 11, 12, 13 and 17); and failed to monitor and review final validation reports and correct errors</p>	G 0322	<p>A. 1. To correct the errors that are on some patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. A. 2. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number being reported within the OASIS</p>	07/15/2016

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	<p>for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The Indiana State Department of Health CASPER report dated 12/01/2015-05/31/2016 evidenced the agency failed to submit information monthly, and evidenced the agency failed to submit OASIS information for December 2015, January 2016, February 2016, and April 2016.</p> <p>A. The ISDH CASPER Report for Home Health Agency (HHA) Activity dated 12/01/2015 thru 05/31/2015 stated "No Data Returned for Selected Criteria."</p> <p>B. The ISDH CASPER Report fro HHA Submission Statistics by Agency dated 12/31/2015 thru 05/31/2016 evidenced the agency submitted on 03/15/3016 at 13:40:30 83 records with 100% rejected, and at 13:41:03 5 records with 100 % rejected; and on 05/10/2016 at 13:53:01 5 records with 100 % rejected, and at 13:53:10 5 records with 100 % rejected.</p> <p>C. The ISDH CASPER Report for HHA Error Summary by Agency dated 12/2015 thru 05/2016 evidenced multiple errors including Incorrect Format, Incorrect CCN, Inconsistent Dates,</p>				<p>is 8888888888. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. A. 3. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a previous accepted OASIS that</p>		

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	<p>Records Submitted Late, Incorrect Format, Inconsistent Record Sequence, Patient Information Mismatch, and Record Timing Invalid.</p> <p>2. On 6/15/16, The agency provided The Centers for Medicare & Medicaid Services (CMS) Submission Report OASIS Agency Final Validation Report dated 03/15/2016 at 13:41:03 stated "# Records Processed: 5, # Production Records Accepted: 0; # Production Records Rejects: 5."</p> <p>A. This report failed to list survey patient #6 (start of care date 12/28/13). Patient #6 had a recertification assessment dated 2/11-2/15/16, which should have been reported in March. This report failed to reflect patient #6 February recertification was submitted.</p> <p>B. This report listed survey patient # 7 (start of care date 9/22/14). The report stated "M0090 Date: 01/13/2016 and Type of Transaction: NEW RECORD ... Date Submitted: 8888888888, Message Number/Severity: -5280 FATAL." This should have been labeled as a recertification, not a new record.</p> <p>C. The report listed survey patient #8 (start of care date 4/8/16). The report stated "M0090 Date: 03/01/2016 ...</p>		<p>was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. B. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. C. The Agency will monitor and review final validation reports and correct errors. D. The Agency will ensure all OASIS data submitted is not rejected. E. The Agency will ensure correction of rejected data. F. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K108	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2016
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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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	<p>NEW RECORD ." The OASIS cannot be collected prior to the start of care date, the clinical record evidenced the referral was not made to the agency until 4/8/16.</p> <p>D. The report listed survey patient # 11 (start of care date 6/10/15). The report stated "M0090 Date: 01/04/2016 ... Type of Transaction: NEW RECORD ... Message: Record Submitted Late: The submission date is more than 30 days after M0090 on this new record." The clinical record for patient # 11 evidenced the most recent recertification prior to 1/4/16 was completed on 12/2/2015. This submission was over 30 days late and was not a new record.</p> <p>1. The next recertification for patient #11 was completed on 2/1/16, and should have been submitted within 30 days.</p> <p>E. The report listed survey patient # 12 (start of care date 7/4/14). The report stated "M0090 Date 12/22/2015 ... NEW RECORD ." The submission is over 30 days late, and was not a new record.</p> <p>1. The clinical record for patient #12 evidenced 12/22/2015 was a recertification and should have been submitted in January.</p> <p>F. This report listed survey patient #</p>		for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0322.	

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	<p>17 (discharged 2/26/16). The report stated "M0090 Date: 02/29/2016 and Type of Transaction: NEW RECORD ... Date Submitted: 8888888888, Message Number/Severity: -5280 FATAL ... OASIS Item(s): M0010_CCN, Stored Value ... Message: Incorrect CCN: M0010 does not match the CMS Certification Number (CCN) in the QIES ASAP System database for the agency identified in the file." This record was a discharge, not a new record.</p> <p>2. On 6/15/16 the agency provided The CMS Submission Report OASIS Agency Final Validation Report dated 3/15/2016 at 13:40:30. This report stated "# Records Processed: 83 ... # Production Records Accepted: 0 ... # Production Records Rejected: 83."</p> <p>A. The report listed survey patient # 13 (start of care date 10/23/14). The report stated "M0090 Date: 6/19/15 ... NEW RECORD;" and "M0090 Date: 08/13/2015 ... NEW RECORD;" and "M0090 Date: 10/16/2015 ... NEW RECORD." These submissions would not have been new records.</p> <p>B. This patient (#13) record evidenced recertifications were completed on 12/16/15 and 2/10/2016 and 4/14/16. The 12/16/15 recertification</p>			

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	<p>should have been submitted in January, and the 2/10/16 recertification should have been submitted in March. No information was provided for May 2016 submissions.</p> <p>3. The agency submitted two documents titled "OASIS File Submission" dated 3/15/2016 at 13:41:03, and 05/10/2016 at 13:53:10. Both documents stated "Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports."</p> <p>4. On 6/14/16 at 10:25 AM, the January OASIS File Submission Report and Final Validation Report was requested. As of 6/21/16 at 11:30 AM, these documents had not been provided.</p> <p>5. During interview on 6/15/16 at 10:20 AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's</p>			

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	<p>electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>6. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible records have been submitted, and all patients are Medicaid patients.</p> <p>7. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from</p>			

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G 0324 Bldg. 00	<p>the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not aware of the location of the submission report.</p> <p>8. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Procedure: HHA will encode and electronically transmit each completed OASIS assessment to the State agency's or the CMS OASIS contractor, regarding the beneficiary with respect to which such information is required to be transmitted within 30 days of completing the assessment of the beneficiary."</p> <p>484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the</p>			

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	<p>requirements of paragraph (d) of this section.</p> <p>Based on document review and interview, the agency failed to ensure all Outcome Assessment Information Set (OASIS) data submitted was not rejected; failed to ensure the monitoring of error reports, and failed to ensure the correction of rejected OASIS data for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The Indiana State Department of Health CASPER report dated 12/01/2015-05/31/2016 evidenced the agency failed to submit information monthly, and evidenced the agency failed to submit OASIS information for December 2015, January 2016, February 2016, and April 2016.</p> <p>A. The ISDH CASPER Report for Home Health Agency (HHA) Activity dated 12/01/2015 thru 05/31/2015 stated "No Data Returned for Selected Criteria."</p> <p>B. The ISDH CASPER Report fro HHA Submission Statistics by Agency dated 12/31/2015 thru 05/31/2016 evidenced the agency submitted on 03/15/3016 at 13:40:30 83 records with 100% rejected, and at 13:41:03 5 records with 100 % rejected; and on 05/10/2016</p>			G 0324	<p>A. 1. To correct the errors that are on some patient records, the Agency worked with both QIES and Brightree (EMR) representatives to correct coding errors. A. 2. The Agency spoke to Dawn at Brightree (EMR) on July 5, 2016 at 1:54 pm regarding the fact that the CCN number being reported within the OASIS is <u>8888888888</u>. This number should only be a 6 digit number and our correct number is 15K108. Both the representative and the Agency tried to correct the number within the Brightree system and it would not allow for this change. The Brightree representative escalated the problem to the next tier of support, with the results being that they believed the number was incorrect because the CCN contained a letter. The Agency then spoke to Roger from the QIES helpline on July 7, 2016 who confirmed that the CCN number provided was indeed the correct number for our facility. The Agency made a return phone call to Dawn at Brightree and the tier 2 support team was able to figure out how to correct the problem. The OASIS were able to be corrected and re-sent successfully. A. 3. Regarding the NEW RECORD issue, the Agency spoke with QIES for assistance with this issue. The Agency spoke with Nick at the</p>		07/15/2016

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	<p>at 13:53:01 5 records with 100 % rejected, and at 13:53:10 5 records with 100 % rejected.</p> <p>C. The ISDH CASPER Report for HHA Error Summary by Agency dated 12/2015 thru 05/2016 evidenced multiple errors including Incorrect Format, Incorrect CCN, Inconsistent Dates, Records Submitted Late, Incorrect Format, Inconsistent Record Sequence, Patient Information Mismatch, and Record Timing Invalid.</p> <p>2. On 6/15/16, The agency provided The Centers for Medicare & Medicaid Services (CMS) Submission Report OASIS Agency Final Validation Report dated 03/15/2016 at 13:41:03 stated "# Records Processed: 5, # Production Records Accepted: 0; # Production Records Rejects: 5."</p> <p>3. On 6/15/16 the agency provided The CMS Submission Report OASIS Agency Final Validation Report dated 3/15/2016 at 13:40:30. This report stated "# Records Processed: 83 ... # Production Records Accepted: 0 ... # Production Records Rejected: 83."</p> <p>4. The agency submitted two documents titled "OASIS File Submission" dated 3/15/2016 at 13:41:03, and 05/10/2016 at</p>		<p>QIES helpline July 14, 2016 regarding each OASIS transaction stating it was a "NEW RECORD". Nick informed the Agency that each record will always state that it is a new record because it is indeed a new record. Each OASIS sent will always be a NEW RECORD unless it is a correction. He explained, that if you have a previous accepted OASIS that was pulled back and a correction made within the assessment, it would then be labeled a correction. In the section labeled RFA, Branch ID is where you find a 2 digit code which tells you what kind of OASIS the record is. For example 09 would be a discharge. This is the delineation for the type of record it is, not the NEW RECORD in the validation report. B. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. C. The Agency will monitor and review final validation reports and correct errors. D. The Agency will ensure all OASIS data submitted is not rejected. E. The Agency will ensure correction of rejected data. F. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all</p>		

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	<p>13:53:10. Both documents stated "Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports."</p> <p>5. During interview on 6/15/16 at 10:20 AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p>		<p>OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0324.</p>	

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	<p>6. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible records have been submitted, and all patients are Medicaid patients.</p> <p>7. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not aware of the location of the submission report.</p> <p>8. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Procedure: HHA will encode and electronically transmit each completed OASIS assessment to the State agency's or the CMS OASIS contractor, regarding</p>			

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G 0332 Bldg. 00	<p>the beneficiary with respect to which such information is required to be transmitted within 30 days of completing the assessment of the beneficiary."</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on document review and interview, the agency failed to ensure the Registered Nurse conducted the initial start of care assessment within 48 hours or on the physician ordered date for 1 of 10 records reviewed. (# 8)</p> <p>Findings include</p> <p>1. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification; beginning week of 4/12/16 SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the SN assess at start of care was completed per date physician</p>			G 0332	<p>A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure</p>		07/15/2016

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	<p>ordered.</p> <p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p> <p>B. During interview on 6/17/16 at 10:30 AM, the Nursing Supervisor stated she could not find any notes in the computer as to why the start of care was not completed in the ordered time frame.</p> <p>2. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Initial Assessment: A registered nurse will conduct an initial assessment visit to determine the immediate care and support needs of the patient and eligibility. This initial assessment visit will be within 48 hours of the referral or within 48 hours of the patient's return home or as ordered by the physician. If the visit can not be made within the required 48 hours, the reason for such must be documented."</p>		continued compliance with this requirement. Director of Nursing will be responsible for ongoing compliance with G0170.	

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G 0334 Bldg. 00	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on document review and interview, the agency failed to ensure the Registered Nurse collected Outcome Assessment and Information Set (OASIS) data on start of care and failed to ensure the information was completed within 5 days of start of care for 1 of 3 records reviewed of patients receiving skilled services. (#8)</p> <p>Findings include</p> <p>1. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification beginning week of 4/12/16; SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the SN assess and evaluate was completed per date physician ordered, and failed to evidence the RN collected OASIS data on admission or within 5 days of start of care.</p>	G 0334	<p>A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date, including OASIS collection at start of care or within 5 calendar days after the start of care. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS assessments for timeliness of completion until 100% compliance is achieved for 6</p>	07/15/2016			

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	<p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p> <p>B. The Initial Evaluation visit dated 4/11/16, failed to evidence the initial start of care assessment included OASIS data, and failed to evidence a reason the visit was not completed until 4/11/16.</p> <p>C. During interview on 6/17/16 at 10:10 AM, the Nursing Supervisor stated the start of care OASIS information is not showing up in the computer, but there is not a way to do any other OASIS assessments without one in the computer. The Nursing Supervisor stated there is not a reason in the computer as to why the RN did not assess for start of care until 4/11/16.</p> <p>2. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Home Healthcare Associates will comply with State and federal guidelines with regards to OASIS data collection and reporting. ... Comprehensive Assessment: (to include the administration of the OASIS) Each patient will receive a patient specific, comprehensive assessment that</p>		<p>months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with G0334.</p>	

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N 0000 Bldg. 00	<p>accurately reflects the patient's current health status ... This assessment (start of care) will be completed by a registered nurse in a timely manner, consistent with patient's immediate needs, but no later than 5 calendar days from the start of care. ... The Comprehensive Assessment will incorporate the use of current OASIS items."</p> <p>This was a home health state licensure survey.</p> <p>Survey Dates: June 14, 15, 16, 17, 20 and 21, 2016</p> <p>Facility Number: 004998</p> <p>Medicaid Number: 15K108</p> <p>Census Service Type: Skilled: 8 Home Health Aide Only: 47 Personal Care Only: 0 Total: 55</p>	N 0000		

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N 0444 Bldg. 00	<p>Sample: RR w/HV: 4 RR w/o HV: 13 Total: 17</p> <p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on document review and interview, the Administrator failed to ensure the day-to-day operations of the agency including accuracy of clinical records, employee qualifications oversight, Outcome Assessment Information Set (OASIS) transmission oversight and validation, and Quality Assessment and Performance Improvement (QAPI) review and oversight for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The agency's job description titled "Administrator," no number, no date, stated "Position Overview Responsible</p>	N 0444	Section 1 (N0608): A. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. B. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. C. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. D. Agency audited 100% of patient	07/15/2016

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	<p>for the administration and direction for Home Healthcare Associates' professional, clinical, and clerical services in accordance with established policies, program objectives, and state and federal standards. ... Essential Job Functions Organizes and directs the agency's ongoing functions. ... Employs qualified personnel and ensures adequate staff education and evaluations. ... Evaluates quality of programs and services, report findings to the governing board, implement recommendations for continuous improvement of services offered. ... Evaluates the agency's overall programs and efficiency."</p> <p>2. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>3. During interview on 6/14/16 at 10:35 AM, the Administrator stated quality assessment includes chart audits which are continual but at least every 60 days and any trends of problems are investigated.</p> <p>4. Clinical record review evidenced the Administrator failed to ensure the accuracy of clinical records and the</p>		<p>charts to determine the presence of consents. Consents were found on 100% of current patient charts. E. Agency will complete patient consents prior to provision of services. F. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. G. The Agency will monitor and review final validation reports and correct errors. H. The Agency will ensure all OASIS data submitted is not rejected. I. The Agency will ensure correction of rejected data. J. The Agency will ensure error reports are monitored. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this requirement. Agency will continue to audit 100% of patient charts for compliance with</p>	

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	<p>education and supervision of HHAs and identify the following problems (See N 608: Discharge summaries failed to include the summary of care provided, and failed to be completed within 30 days of discharge; Home Health Aide and Registered Nurse visit notes were not recorded timely; consent for services was not signed prior to providing care (See n 494; failed to ensure skilled nurse (SN) assessments were completed within 48 hours of ordered dates (See N 537); SN followed did not follow plans of care, missed visits were not reported to physician, and plans of care frequencies were not accurate (See N 522); and failed to oversee the supervision of HHAs by the RNs to ensure appropriate care, scope, and supervision was provided (See N 596).</p> <p>5. Home visits evidenced the Administrator failed to ensure all staff were following agency's policies and procedures for infection control (See N 470).</p> <p>6. Employee file reviewed evidenced the Administrator failed to oversee the education and qualifications of employees and failed to identify following problems (See N 458 and 460): 1 HHA had an expired certification and was not on the Indiana Nurse Aide</p>		<p>obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. Section 2 (N0494): A. 1. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. A. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will</p>	

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	<p>Registry and was providing care to patients; criminal background checks were not completed within 3 days of starting patient care for 3 of 6 employees; 3 of 4 HHAs did not take a HHA competency test; annual evaluations were not completed for 1 of 2 RNs; and didactic information was not separated from medical information for 1 of 6 files reviewed (See N 466).</p> <p>7. Review of QAPI evidenced the Administrator failed to oversee and identify the following problems for the agency: monthly transmission of OASIS data; the accuracy of OASIS data and monitor and follow up with final validation reports to ensure correction of any identified errors (See N 456).</p> <p>8. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were</p>		<p>continue to audit 10% of all patient charts to determine ongoing compliance with standard. Section 3 (N0537): A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. Section 4 (N0522): A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. C. The Agency will track all missed visits and the 60-day</p>		

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	<p>reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p> <p>A. The Governing Body board meeting dated 2/15/16 only included the agency's budget and changes in staff, and failed to include employee file review, and OASIS review.</p> <p>9. The agency's policy titled "Organizational Performance Improvement Plan," no number, no date, stated "Purpose: ... Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment and services. ... Policy: ... Home Healthcare Associates performance improvement plan is evaluated at least annually and revised as necessary. ... Information from departments/services and the findings of discrete performance improvement activities are analyzed to detect trends, patterns of performance or potential problems that may impact more than one (1) department/service. ... Scope of Activities: The cope of the organizational performance improvement program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care, treatment and</p>		<p>summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. D. The Agency will accurately document each patient's visit frequency on all Plans of Care and the Agency will not utilize "0" as a visit frequency. E. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of-care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. 4. To accurately document visit frequencies and that "0" is not a valid frequency. 5. To obtain physicians orders for all home health visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will</p>	

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	services and patient and staff safety practices. The program consists of these focus components: performance improvement, patient/staff safety, quality assessment/improvement and quality control activities. ... Assessment of the performance of the following patient care and organizational functions are included: ... Provision of Care, Treatment and Services ... Leadership ... Surveillance, Prevention and Control of Infection ... Improving Organization Performance."		audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders , specifically the ordered visit frequencies, to ensure the accurate visit frequencies are documented and physician orders are obtained for any additional visits . The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders until 100% compliance is maintained for a period of 6 months. After that the Agency will continue to audit 10% of all Medical Plans-of- Care and Physician verbal orders for accurate visit orders and frequencies on an ongoing basis to ensure continued compliance with this requirement. Section 5 (N0596): A. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation		

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			<p>passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B. The Agency will complete home health aide competency evaluation program prior to patient contact. (For a period of two years beginning June 21, 2016, this competency evaluation program will be conducted by an independent outside provider as Home Healthcare Associates is prohibited from providing said program during that time frame.) The Agency will ensure continuing compliance by auditing 100% of employee files for presence of HHA written competency evaluation prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. Section 6 (N0458): A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1.</p>	

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			<p>Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. C. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. D.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the</p>	

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			<p>written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. D.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact.</p> <p>E. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. E.2. Agency will ensure compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard.</p> <p>Section 7 (N0460): A. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. A. 2. Agency will ensure continuing compliance by auditing 100% of</p>	

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			<p>employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. C.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. C. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until</p>	

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			findings as part of the QAPI program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program to ensure continued compliance with this requirement. Section 8 (N0466): A. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. The Agency will ensure that medical information is kept separate from administrative records. A.2. Agency will ensure compliance by auditing 100% of employee files to ensure that confidential medical information is kept separate from administrative records until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. Section 9 (N0456): A. The Agency will transmit all available OASIS data to the state	

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N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or		agency monthly and within 30 days after the assessment is completed. B. The Agency will monitor and review final validation reports and correct errors. C. The Agency will ensure all OASIS data submitted is not rejected. D. The Agency will ensure correction of rejected data. E. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator is responsible for ongoing compliance with N0444.	

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	<p>registered nurse required by subsection (d), shall do the following:</p> <p>(6) Ensure that the home health agency meets all rules and regulations for licensure. Based on document review and interview, the Administrator failed to ensure the day-to-day operations of the agency including accuracy of clinical records, employee qualifications oversight, Outcome Assessment Information Set (OASIS) transmission oversight and validation, and Quality Assessment and Performance Improvement (QAPI) review and oversight for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The agency's job description titled "Administrator," no number, no date, stated "Position Overview Responsible for the administration and direction for Home Healthcare Associates' professional, clinical, and clerical services in accordance with established policies, program objectives, and state and federal standards. ... Essential Job Functions Organizes and directs the agency's ongoing functions. ... Employs qualified personnel and ensures adequate staff education and evaluations. ... Evaluates quality of programs and services, report findings to the governing board, implement recommendations for continuous improvement of services</p>	N 0449	<p>Section 1 (N0608): A. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. B. 1. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. B. 2. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. C. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. D. Agency will complete patient consents prior to provision of services. E. The Agency will transmit all available OASIS data to the state agency monthly and within 30 days after the assessment is completed. F. The Agency will monitor and review final validation reports and correct errors. G. The Agency will ensure all OASIS data submitted is not rejected. H. The Agency will ensure correction of rejected data. I. The Agency will</p>	07/15/2016

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	<p>offered. ... Evaluates the agency's overall programs and efficiency."</p> <p>2. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>3. During interview on 6/14/16 at 10:35 AM, the Administrator stated quality assessment includes chart audits which are continual but at least every 60 days and any trends of problems are investigated.</p> <p>4. Clinical record review evidenced the Administrator failed to ensure the accuracy of clinical records and the education and supervision of HHAs and identify the following problems (See N 608): Discharge summaries failed to include the summary of care provided, and failed to be completed within 30 days of discharge; Home Health Aide and Registered Nurse visit notes were not recorded timely; consent for services was not signed prior to providing care (See N 494); failed to ensure skilled nurse (SN) assessments were completed within 48 hours of ordered dates (See N 537); SN followed did not follow plans of care, missed visits were not reported to</p>		<p>ensure error reports are monitored. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this requirement. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will</p>	

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	<p>physician, and plans of care frequencies were not accurate (See N 522); and failed to oversee the supervision of HHAs by the RNs to ensure appropriate care, scope (See N 606).</p> <p>5. Home visits evidenced the Administrator failed to ensure all staff were following agency's policies and procedures for infection control (See N 470).</p> <p>6. Employee file reviewed evidenced the Administrator failed to oversee the education and qualifications of employees and failed to identify following problems (See N 458 and N460): 1 HHA had an expired certification and was not on the Indiana Nurse Aide Registry and was providing care to patients; criminal background checks were not completed within 3 days of starting patient care for 3 of 6 employees; 3 of 4 HHAs did not take a HHA competency test; annual evaluations were not completed for 1 of 2 RNs; and didactic information was not separated from medical information for 1 of 6 files reviewed.</p> <p>7. Review of OASIS data reports evidenced the Administrator failed to oversee and identify the following problems for the agency: monthly</p>		<p>audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. Section 2 (N0494): A. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. Section 3 (N0537): A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. The</p>	

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	<p>transmission of OASIS data to the State, the accuracy of OASIS data, and monitor and follow up with final validation reports to ensure correction of any identified errors (See N 472).</p> <p>8. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p> <p>A. The Governing Body board meeting dated 2/15/16 only included the agency's budget and changes in staff, and failed to include employee file review, and OASIS review.</p> <p>9. The agency's policy titled "Organizational Performance Improvement Plan," no number, no date, stated "Purpose: ... Identify, on an</p>		<p>Agency will audit 100% of all referrals and dates of the start-of-care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. Section 4 (N0522):</p> <p>A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. C. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. D. The Agency will accurately document each patient's visit frequency on all Plans of Care and the Agency will not utilize "0" as a visit frequency. E. The Agency has educated all clinicians and support staff on the following: 1. The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of-</p>	

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	ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment and services. ... Policy: ... Home Healthcare Associates performance improvement plan is evaluated at least annually and revised as necessary. ... Information from departments/services and the findings of discrete performance improvement activities are analyzed to detect trends, patterns of performance or potential problems that may impact more than one (1) department/service. ... Scope of Activities: The cope of the organizational performance improvement program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care, treatment and services and patient and staff safety practices. The program consists of these focus components: performance improvement, patient/staff safety, quality assessment/improvement and quality control activities. ... Assessment of the performance of the following patient care and organizational functions are included: ... Provision of Care, Treatment and Services ... Leadership ... Surveillance, Prevention and Control of Infection ... Improving Organization Performance."		care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. 4. To accurately document visit frequencies and that "0" is not a valid frequency. 5. To obtain physicians orders for all home health visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. The Agency will audit 100% of the medical Plans-of- Care and Physician verbal orders , specifically the ordered visit frequencies, to ensure the	

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			<p>accurate visit frequencies are documented and physician orders are obtained for any additional visits . The Agency will audit 100% of the medical Plans-of-Care and Physician verbal orders until 100% compliance is maintained for a period of 6 months. After that the Agency will continue to audit 10% of all Medical Plans-of- Care and Physician verbal orders for accurate visit orders and frequencies on an ongoing basis to ensure continued compliance with this requirement. Section 5 (N0606): A. 1. Agency educated all clinical staff on the policy regarding Home Health Aides and the administration of medication with specific attention to medicated lotions. A. 2. Agency will ensure continued compliance by unannounced site visits to ensure compliance until 100% compliance is achieved for 6 months, and then ongoing surveillance via unannounced site visits will be conducted to ensure continued compliance with standard. Section 6 (N0470): A. Agency will comply with infection control policy and procedures. B. Agency has educated all staff on the following: 1. Hand Rub Policy and Procedure 2. Hand Washing Policy and Procedure C. Agency evaluated education using written exam to determine competency regarding hand rub and hand wash policies and procedures. Agency will ensure</p>	

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			<p>compliance with N0470 by unannounced on site visits until 100% compliance is achieved for 6 months. Agency will track this using a hand rub/hand wash evaluation form completed by RN staff. Section 7 (N0458): A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the</p>	

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			<p>correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file.</p> <p>C. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard.</p> <p>D.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file.</p> <p>D.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact.</p> <p>E. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations</p>	

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			<p>from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. E.2. Agency will ensure compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. Section 8 (N0460): A. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files until</p>	

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			100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. C.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. C. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual meetings thereafter to ensure continued compliance with this requirement. D. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program. D. 2. Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a	

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			<p>period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this requirement. E. 1. The Agency will review the OASIS program as part of the QAPI program. E.2. The Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program to ensure continued compliance with this requirement. Section 9 (N0472): A.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review</p>	

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			including but not limited to transmission, timeliness of completion, and accuracy. A. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual meetings thereafter to ensure continued compliance with this requirement. B. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program. B. 2. Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this	

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815		
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N 0456 Bldg. 00	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on document review and	N 0456	requirement. C. 1. The Agency will review the OASIS program as part of the QAPI program. C.2. The Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program to ensure continued compliance with this requirement. The Administrator is responsible for ensuring ongoing compliance with N0449. A. The Agency will transmit all	07/15/2016	

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	<p>interview, the agency's failed to ensure the annual evaluation conducted in November 2015 included oversight of Outcome Assessment and Information Set (OASIS) data final validation reports and possible error correction for 1 of 1 agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The Governing Body board meeting dated 2/15/16 failed to include employee file review, and OASIS review. 2. During interview on 6/14/15 at 10:35 AM, the Administrator stated the agency does do look back evaluations of OASIS data to make sure they get the same scores as the assessments by the nurses. 3. During interview on 6/15/16 at 10:20 AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving 		<p>available OASIS data to the state agency monthly and within 30 days after the assessment is completed. B. The Agency will monitor and review final validation reports and correct errors. C. The Agency will ensure all OASIS data submitted is not rejected. D. The Agency will ensure correction of rejected data. E. The Agency will ensure error reports are monitored. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with N0456.</p>	

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	<p>them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>4. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible records have been submitted, and all patients are Medicaid patients.</p> <p>5. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not</p>			

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N 0458 Bldg. 00	<p>aware of the location of the submission report.</p> <p>6. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p> <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:</p>			

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	<p>(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. Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H); failed to ensure criminal background checks were completed within 3 days of starting patient care for 3 of 6 employee files reviewed (B, H, and G); failed to ensure 3 of 4 HHAs completed the HHA competency test (E, F, and H); and failed to ensure 1 of 2 Registered Nurse (RN) files contained an annual evaluation.</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test, and failed to evidence a criminal background check had been conducted until 6/20/16. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the</p>	N 0458	<p>A. 1. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. C. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the</p>	07/15/2016

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	<p>employee "completed a competency evaluation program required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated she ran the background check for employee H on date of hire, but cannot find it. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file B was reviewed on 6/20/16. At time of hire, employee B was an as needed (PRN) RN. Date of hire and first patient contact dates</p>		<p>correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. C. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. D.1. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. D.2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. E. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations</p>		

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	<p>12/12/13. The file failed to evidence the criminal background check was sent in until 12/18/13, and failed to evidence annual performance evaluations for 2014 and 2015.</p> <p>A. During interview on 6/20/16 at 10:15 AM, employee I (Office Manager) stated employee B was part time and just hired full time within the last 3 months, so not sure how much she worked prior to that.</p> <p>B. During interview on 6/20/16 at 11:30 AM, the Alternate Administrator stated she was PRN for 2 years and probably only made 2 visits- she does not know that an annual evaluation was completed. She stated she recently took the Alternate Administrator position around February of this year.</p> <p>3. Employee file G, RN, was reviewed on 6/20/16. Date of hire 3/10/14, first patient contact date 3/14/14. The file failed to evidence the criminal background check was sent in until 4/29/14.</p> <p>A. During interview on 6/21/16 at 9:10 AM, the Alternate Administrator stated these older criminal checks were in storage, but the Administrator could not locate the original for employee G.</p>		<p>from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. E.2. Agency will ensure compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. The Administrator is responsible for ensuring ongoing compliance with N0458.</p>	

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	<p>4. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>5. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>6. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure on the part of the employee to provide this document will relieve Home Healthcare Associates of any employment obligations. The employee will be considered unable to perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of</p>			

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	<p>the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p> <p>7. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meets the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>8. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <p>9. The agency's policy titled "Employee Background Check," Version 1, reviewed 6/1/15, stated "Pre-Offer Background Check. Before extending an offer of employment to a job applicant: a. For individuals who have not lived outside of the state of Indiana in the previous two years, HHCA will obtain a copy of the individual's limited criminal history check from the Indiana State Police</p>			

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N 0460 Bldg. 00	<p>Repository."</p> <p>10. The agency's policy titled "Performance Evaluations," no number, no date stated "Annual Performance Evaluation for all Employees: This document is completed on the employee's anniversary date for all employees who have successfully completed their first year of employment."</p> <p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on document review and interview the agency failed to ensure the criminal background check for the Nursing Supervisor (employee B) was completed within 3 days of starting patient care; and failed to ensure the annual evaluation conducted in November 2015 included oversight of Outcome Assessment and</p>	N 0460	A. 1. Agency audited 100% of employee files for compliance with Criminal background check reports. 100% of current employees were found to have current Criminal background check reports. A. 2. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact until 100%	07/15/2016

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	<p>Information Set (OASIS) data final validation reports and possible error correction for 1 of 1 agency.</p> <p>Findings include</p> <p>1. Employee file B (Alternate Administrator/Nursing Supervisor) was reviewed on 6/20/16. Date of hire and first patient contact dates 12/12/13. The file failed to evidence the criminal background check was sent in until 12/18/13, and failed to evidence annual performance evaluations for 2014 and 2015.</p> <p>A. During interview on 6/20/16 at 10:15 AM, employee I (Office Manager) stated employee B was part time and just hired full time within the last 3 months, so not sure how much she worked prior to that.</p> <p>B. During interview on 6/20/16 at 11:30 AM, the Alternate Administrator stated she was PRN for 2 years and probably only made 2 visits- she does not know that an annual evaluation was completed. She stated she recently took the Alternate Administrator/Nursing Supervisor positions around February of this year.</p> <p>2. The agency's policy titled "Employee</p>		<p>compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. B. 1. Agency audited 100% of employee files for compliance with annual evaluations. Missing annual evaluations were located after the survey was completed and have been placed in the correct order in the employee file. 100% of current employees employed greater than 12 months were found to have annual evaluations in their employee file. B. 2. Agency will ensure continuing compliance by auditing 100% of employee files until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard. C.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. C. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual</p>	

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	<p>Background Check," Version 1, reviewed 6/1/15, stated "Pre-Offer Background Check. Before extending an offer of employment to a job applicant: a. For individuals who have not lived outside of the state of Indiana in the previous two years, HHCA will obtain a copy of the individual's limited criminal history check from the Indiana State Police Repository."</p> <p>3. The agency's policy titled "Performance Evaluations," no number, no date stated "Annual Performance Evaluation for all Employees: This document is completed on the employee's anniversary date for all employees who have successfully completed their first year of employment."</p> <p>4. The Governing Body board meeting dated 2/15/16 only included the agency's budget and changes in staff, and failed to include employee file review, and OASIS review.</p> <p>5. During interview on 6/14/15 at 10:35 AM, the Administrator stated the agency does do look back evaluations of OASIS data to make sure they get the same scores as the assessments by the nurses.</p> <p>6. During interview on 6/15/16 at 10:20 AM, the Administrator stated the</p>		<p>meetings thereafter to ensure continued compliance with this requirement. D. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program. D. 2. Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this requirement. E. 1. The Agency will review the OASIS program as part of the QAPI program.E.2. The Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program until 100% compliance is</p>	

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815		
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	<p>agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>7. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible records have been submitted, and all</p>		<p>maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program to ensure continued compliance with this requirement. The Administrator will be responsible for ensuring ongoing compliance with N0460.</p>		

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	<p>patients are Medicaid patients.</p> <p>8. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not aware of the location of the submission report.</p> <p>9. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p>			

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N 0466 Bldg. 00	<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). Based on document review and interview the agency failed to ensure didactic information was separate from medical information for 1 of 6 files reviewed (E).</p> <p>Findings include</p> <p>1. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. The medical file failed to evidence all documents were medical related.</p> <p>A. Employee F's medical file contained a Use and disclosure form, and Certificate of Completion for Adult First Aid/CPR [cardiopulmonary resuscitation].</p> <p>B. During interview on 6/20/16 at</p>	N 0466	<p>A. 1. Agency developed policy and procedure for order of employee documents in employee files. 100% of employee files were audited for compliance with this policy and procedure and any deviations from this were corrected. 100% of employee files are now in compliance with new agency policy and procedure related to employee document order. The Agency will ensure that medical information is kept separate from administrative records. A.2. Agency will ensure compliance by auditing 100% of employee files to ensure that confidential medical information is kept separate from administrative records until 100% compliance has been achieved for 6 months, and then 10% of employee files will be audited for maintained compliance with this standard. The Administrator will</p>	07/11/2016

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N 0470 Bldg. 00	<p>9:20 AM, employee I stated those two forms should not be in the medical portion of the file.</p> <p>C. During interview on 6/20/16 at 11:00 AM, the Alternate Administrator stated they do not see a policy for the order of employee files information.</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, document review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 2 of 5 home visits. (patient # 1 and 14)</p> <p>Findings include</p> <p>1. During home visit observation with patient #1 on 6/15/16 at 2:00 PM, employee C (Alternate Nursing Supervisor) was observed providing care. Upon arrival to the home, employee C was observed to wash hands for only 15 seconds total time.</p>			N 0470	<p>be responsible for ongoing compliance with N0466.</p> <p>A. Agency will comply with infection control policy and procedures. B. Agency has educated all staff on the following: 1. Hand Rub Policy and Procedure 2. Hand Washing Policy and Procedure C. Agency evaluated education using written exam to determine competency regarding hand rub and hand wash policies and procedures. Agency will ensure compliance with N0470 by unannounced on site visits until 100% compliance is achieved for 6 months. Agency will track this using a hand rub/hand wash evaluation form completed by RN staff. Director of Nursing will be responsible for ensuring ongoing compliance with</p>		07/15/2016

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N 0472 Bldg. 00	<p>2. During interview on 6/16/16 at 2:40 PM, the Alternate Administrator stated the hand washing policy is 40-60 seconds for the entire hand wash procedure.</p> <p>3. During home visit observation with patient # 14 on 6/16/16 at 1:45 PM, employee F, home health aide, was observed. After emptying the dishwasher and washing dirty dishes, employee F removed gloves and washed hands for approximately 5 seconds. Employee F failed to wash her hands longer than 5 seconds.</p> <p>A. After sweeping the kitchen floor and removing gloves, employee F failed to wash her hands for more than 10 seconds.</p> <p>4. The agency's procedure titled "Patient Safety," from the World Health Organization, revised August 2009 stated "Save Lives Clean Your Hands ... How? ... Wash your hands with soap and water when hands are visibly dirty or visibly soiled with blood or other body fluids or after using the toilet. ... Duration of the entire procedure: 20-30 seconds."</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and</p>		N0470.	

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	<p>evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on document review and interview, the agency's failed to ensure the annual evaluation conducted in November 2015 included oversight of Outcome Assessment and Information Set (OASIS) data final validation reports and possible error correction for 1 of 1 agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The Governing Body board meeting dated 2/15/16 only included the agency's budget and changes in staff, and failed to include employee file review, and OASIS review. 2. During interview on 6/14/15 at 10:35 AM, the Administrator stated the agency does do look back evaluations of OASIS data to make sure they get the same scores as the assessments by the nurses. 3. During interview on 6/15/16 at 10:20 	N 0472	<p>A.1. Governing Body met on 7/11/2016 to adopt plan to review dashboard audit results and quarterly reports at meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy. A. 2. Governing Body will review 100% of dashboard audit results and quarterly reports at quarterly meetings regarding employee file review audit results and OASIS review including but not limited to transmission, timeliness of completion, and accuracy until 100% compliance is maintained for 6 months, and then at annual meetings thereafter to ensure continued compliance with this requirement. B. 1. Agency will timely complete, transmit, review accuracy of information, note trending of issues, identify accuracy of transmission, detection of errors, and correction of any errors found of OASIS data to evaluate the OASIS program. B. 2. Agency will audit 100% of</p>	07/11/2016

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	<p>AM, the Administrator stated the agency's process is that she and the Alternate Administrator review all OASIS assessments for accuracy within the EMR, lock them, and the office manager (employee I) submits the data via the OASIS designated computer. The Administrator stated the agency's electronic medical records (EMR) system Brightree is connected to report the OASIS data and the agency has not had any error reports in 2 years except for about 1 year ago when it kept giving them the error about not having a Medicare number. The Administrator stated it was last May when they last had issues, they involved CMS and Brightree for resolution. The Administrator stated they have not submitted monthly due to all their skilled patients are due for recertifications at the same time (every 60 days) unless someone goes to the hospital, or etcetera.</p> <p>4. During interview on 6/15/16 at 11:15 AM, the Administrator stated they did a test submission last year with purposeful errors to be sure the problem was corrected, and an error report was sent electronically to the agency; and the ER was set up to electronically send error reports to the agency versus the agency having to print out all those final validation reports- but all OASIS eligible</p>		<p>skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program to ensure continued compliance with this requirement. C. 1. The Agency will review the OASIS program as part of the QAPI program. C.2. The Agency will audit 100% of skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program until 100% compliance is maintained for a period of 6 months. After that, the agency will audit 10% of all skilled patient OASIS assessments for timely completion, timely transmission, accuracy of information, trending of issues, and accuracy of transmission to evaluate the OASIS program and track these findings as part of the QAPI program to ensure continued</p>	

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	<p>records have been submitted, and all patients are Medicaid patients.</p> <p>5. During interview on 6/15/16 at 12:00 PM, the Administrator stated the agency does look at OASIS in quality assurance when they receive error reports, but they have not received any phone calls from the State asking questions about their submissions. The Administrator stated the previous person who was doing the OASIS submissions in January is no longer here, and the Administrator is not aware of the location of the submission report.</p> <p>6. The agency's document titled "Quality Performance Improvement Review," dated 1st quarter January February and March 2016 identified client infections and need for hand washing education among staff to help stop the spread of infections. This was the only document with identified trends in the Quality Review notes for 1st quarter 2016. The QAPI book for 2016 evidenced the agency reviewed complaints, falls, incidents, infections, record review, and sharps injuries. The QAPI book failed to evidence OASIS validations were reviewed and any problems were identified. The Administrator failed to evaluate the agency's OASIS program.</p>		<p>compliance with this requirement. The Administrator is responsible for ensuring ongoing compliance with N0472.</p>	

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N 0494 Bldg. 00	<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:</p> <p>(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.</p> <p>(2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on document review, and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment in 1 of 14 records reviewed. (#7)</p> <p>Findings include</p> <p>1. The clinical record for patient #7 was reviewed on 6/17/16. Start of care date 9/22/14. The record failed to evidence the patient had signed a consent for services form and failed to evidence the agency retained notification of patient</p>	N 0494	<p>A. 1. Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. A. 2. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance with standard. The Director of Nursing will be responsible for ensuring ongoing compliance with N0494.</p>	07/15/2016

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N 0522 Bldg. 00	<p>rights for this admission.</p> <p>2. During interview on 6/17/16, at 11:30 AM, the Alternate Administrator stated she could not find the consent for services for 9/22/14.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on document review and interview, the agency's failed to ensure the Registered Nurse completed the start of care as ordered for 1 of 10 records reviewed (#8); failed to ensure missed visits were reported to the physicians for 4 of 10 clinical records reviewed (# 2, 3, 5, and 8); failed to obtain an order for 1 extra HHA visit (#2); and failed to ensure discipline frequencies did not include a frequency of 0 (zero) for 4 of 10 clinical records reviewed (# 3, 4, 6 and 9).</p> <p>Findings include</p> <p>1. During interview on 6/16/16 at 3:00 PM, the Nursing Supervisor/Alternate Administrator stated the agency has to</p>	N 0522	<p>A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of referral or on the physician ordered start-of- care date. B. The Agency will track all missed visits in the Brightree system (EMR) by documenting the missed visits in the Missed Visit Log. C. The Agency will track all missed visits and the 60-day summary will include documentation of the missed visits to ensure the physician is notified of the missed visits. D. The Agency will accurately document each patient's visit frequency on all Plans of Care and the Agency will not utilize "0" as a visit frequency. E. The Agency has educated all clinicians and support staff on the following: 1. The requirement to</p>	07/15/2016

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	<p>enter a 0 for some frequencies which only have a day or two at the beginning of the certification period so that the computer will accept the information for visits, the 0 frequency visit is not a billable visit; and this includes having to enter skilled nurse (SN) visits for Home Health Aide (HHA) supervisory visits even when patients are HHA only.</p> <p>2. During interview on 6/17/16 at 1:20 PM, the Nursing Supervisor/Alternate Administrator stated the agency does not send missed visit notifications to the physicians if the patient refuses care or has an appointment, but they do for other reasons. The Nursing Supervisor stated the 6/11 miss for patient #2 was a no call no show by the HHA and the agency was not aware until the following day.</p> <p>3. During interview on 6/17/16 at 1:25 PM, employee I (Office Manager) stated the physician was not notified about patient #2's missed visit from 6/11, that patient lives in a group home and they group home does not like to give the agency time to find replacement staff.</p> <p>4. During interview on 6/17/16 at 1:35 PM, employee I stated she usually does not put anything in communication notes when there is a missed visit, she just documents the missed visit in the</p>		<p>perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. 2. The necessity to inform the physician of all missed visits and to include documentation of all missed visits on the 60 day summary. 3. The Missed Visit Log book to document the tracking of missed visits. 4. To accurately document visit frequencies and that "0" is not a valid frequency. 5. To obtain physicians orders for all home health visits. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of all 60 day summaries to ensure all missed visits are reported to the physician until 100% compliance is maintained for a period of 6 months to ensure physicians are notified of missed visits. After that the Agency will continue to audit 10% of the 60 day summaries to ensure continued compliance with this requirement. The Agency will audit 100% of the</p>	

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	<p>computer with reason for the miss.</p> <p>5. During interview on 6/15/16 at 12:00 PM, the Administrator stated the plan of care summaries are the 60 day summaries which are sent to the physicians with the recertification paper work.</p> <p>6. The agency's policy titled "Missed Visits," no number, no date, stated "Procedure: If the staff member is unable to replaced and the patient's Plan of Care visit frequency is not met, the missed visit will be recorded and the patient's physician will be notified on the next plan of care. If the patient has several missed visits due to staff call off or at patient's request, the physician will be notified immediately either in writing or verbally via telephone and documented as such."</p> <p>7. The clinical record for patient #2 was reviewed on 6/17/16. Start of Care date 3/10/16. The plan of care dated 5/9-7/7/16 contained orders for Aide 6 times a week for 1 week, 7 times a week for 7 weeks, and 5 times a week for 1 week. Diagnosis was Profound Intellectual Disability. The record failed to evidence HHA visits were conducted on 5/23, 5/24, 5/28, and 6/11/16. The record failed to evidence an order was obtained for an extra HHA visit the week</p>		<p>medical Plans-of- Care and Physician verbal orders , specifically the ordered visit frequencies, to ensure the accurate visit frequencies are documented and physician orders are obtained for any additional visits . The Agency will audit 100% of the medical Plans-of-Care and Physician verbal orders until 100% compliance is maintained for a period of 6 months. After that the Agency will continue to audit 10% of all Medical Plans-of- Care and Physician verbal orders for accurate visit orders and frequencies on an ongoing basis to ensure continued compliance with this requirement. The Director of Nursing is responsible for ensuring ongoing compliance with N0522.</p>	

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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	<p>of 4/7-4/9/16.</p> <p>A. The documents titled "Daily Schedule" for patient #2 dated 5/23, 5/24, 5/28, and 6/11/16 stated "Comments- Staff refused alternate caregiver." These forms failed to evidence the physician was notified of the missed visits for 5/23, 5/24, and 5/28 immediately in writing or verbally via telephone as per agency policy. The 6/11 missed visit form failed to state this was a no call no show by the HHA.</p> <p>8. The clinical record for patient # 3 was reviewed on 6/17/16. Start of care date 12/19/13. The plan of care dated 4/7-6/5/16 contained orders for SN every 30 days for 60 days with 2 PRN for supervision of HHA, change in condition and recertification; and beginning 4/7/15 HHA 2 times a week for 1 week, 6 times a week for 8 weeks, and 0 times a week for 1 week. The last week of the certification period started 6/5/16, the frequency should have included HHA 1 time for 1 week. The record evidenced 3 visits were conducted by the HHA, and failed to evidence the physician was notified of 4 missed visits.</p> <p>A. During interview on 6/15/16, the Nursing Supervisor stated 6/5 should have been listed as 1 time a week for 1</p>			

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	<p>week.</p> <p>B. The record evidenced HHA services were provided 3 times in the first week of care on 4/7, 4/8, and 4/9/16. The agency failed to follow the frequency ordered, and failed to obtain an order for this extra visit.</p> <p>C. The record evidenced 4 missed HHA visits on 4/23, 5/14, 5/15, and 6/3/16; the "Daily Schedule" note for patient #8 dated 4/23 stated "Staff declined alt aide and time;" the "Daily Schedule" note dated 5/14 and 5/15/16 stated "Staff refused alternate time or caregiver;" the "Daily Schedule" note dated 6/3/16 stated "Staff refused alternate time."</p> <p>D. During interview on 6/17/16 at 2:30 PM, employee I stated the physician was not notified of the missed visits for patient #3 and on 5/14 and 5/15 the assigned HHA was in the hospital and the group home said it was okay to not send other staff.</p> <p>9. The clinical record for patient # 4 was reviewed on 6/20/16. Start of care 2/9/16. The plan of care dated 4/9-6/7/16 contained orders for Aide 0 times a week fro 1 week, 5 times a week for 8 weeks and 2 times a week for 1 week. The</p>			

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	<p>frequency for the first week should not have been 0.</p> <p>10. The clinical record for patient # 5 was reviewed on 6/20/16. Start of care 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for SN 30 days for 60 days and 2 PRN for change in condition, HHA supervision and recertification in last 5 days of certification period; and beginning on 5/8/16, Aide 5-10 times a week for 8 weeks, 3-6 times a week for 1 week, each visit up to 10 hours total, may do multiple visits a day as needed to accommodate patients outside appointments. The record failed to evidence the physician was notified of a missed visit on 5/30/16.</p> <p>A. The record evidenced a missed HHA visit on 5/30/16.</p> <p>B. During interview on 6/20/16 at 2:45 PM, the Nursing Supervisor stated she does not see documentation of a reason for the 5/30 missed visit, and the physician was not notified.</p> <p>11. The clinical record for patient # 6 was reviewed on 6/15/16. The plan of care dated 4/16-6/14/16 contained orders for Skilled Nurse (SN) 0 times a week for 1 week; 3 times a week for 8 weeks; and</p>			

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	<p>1 time a week for 3 weeks; and HHA 1 time a week for 1 week, 7 times a week for 8 weeks, and 3 times a week for 1 week. The record failed to evidence a SN frequency other than 0 for week 1.</p> <p>12. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification; beginning week of 4/12/16 SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the physician was notified of a missed SN visit the week of 5/15-5/21/16, and the record failed to evidence the SN assess and evaluate was completed per date physician ordered.</p> <p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p> <p>B. The record failed to evidence a SN visit was conducted the week of 5/15-5/21/16.</p> <p>C. During interview on 6/17/16 at 10:30 AM, the Nursing Supervisor stated she could not find a reason for the missed</p>			

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N 0537 Bldg. 00	<p>visit the week of 5/15-/521, and there are not any notes in the computer stating a visit was missed.</p> <p>D. The Plan of Care Summary dated certification end 6/6/2016 failed to evidence an missed visits were reported to the physician.</p> <p>E. The Skilled Nurse Visit Note dated 5/4/16 stated "Anticipated next visit scheduled: 05/17/2016.</p> <p>13. The agency's policy titled "Plan of Care," no number, no date, stated "The Nursing Plan of Care must contain the following: ... The frequency and duration of visits."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on document review and interview, the agency failed to ensure the</p>	N 0537	A. The Agency will complete all start-of- care comprehensive assessments within 48 hours of	07/15/2016

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	<p>Registered Nurse completed the initial assessment/start of care within the date range ordered by the physician for 1 of 10 clinical records reviewed (#10).</p> <p>Findings include</p> <p>1. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification beginning week of 4/12/16; SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the physician was notified of a missed SN visit the week of 5/15-5/21/16, and the record failed to evidence the SN assess and evaluate was completed per date physician ordered.</p> <p>A. The Initial Evaluation visit was not conducted until 4/11/16. The record failed to evidence a reason for the initial visit not being done between 4/8-4/10/16 per physician orders.</p> <p>B. The record failed to evidence a SN visit was conducted the week of 5/15-5/21/16.</p> <p>C. During interview on 6/17/16 at 10:30 AM, the Nursing Supervisor stated</p>		<p>referral or on the physician ordered start-of- care date. B. The Agency has educated all clinicians and support staff on the following: The requirement to perform the start-of- care comprehensive assessment within 48 hours of referral or on the physician ordered start-of- care date. The Agency will audit 100% of all referrals and dates of the start-of- care comprehensive assessments until 100% compliance is maintained for a period of 6 months to ensure all patient admissions are conducted within 48 hours of the referral or on the physician ordered start-of- care date. After that the Agency will continue to audit 10% of the clinical records on an ongoing basis to ensure continued compliance with this requirement. The Director of Nursing is responsible for ensuring ongoing compliance with N0537.</p>	

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N 0544 Bldg. 00	<p>she could not find a reason for the missed visit the week of 5/15-/521, and there are not any notes in the computer stating a visit was missed.</p> <p>D. The Plan of Care Summary dated certification end 6/6/2016 failed to evidence an missed visits were reported to the physician.</p> <p>E. The Skilled Nurse Visit Note dated 5/4/16 stated "Anticipated next visit scheduled: 05/17/2016.</p> <p>2. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Initial Assessment: A registered nurse will conduct an initial assessment visit to determine the immediate care and support needs of the patient and eligibility. This initial assessment visit will be within 48 hours of the referral or within 48 hours of the patient's return home or as ordered by the physician. If the visit can not be made within the required 48 hours, the reason for such must be documented."</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health</p>			

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	<p>setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care provided for 2 of 4 discharge records reviewed (# 9, and 10); failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (# 9); and failed to ensure RNs documented visits timely for 3 of 10 clinical records reviewed (# 4, 5, and 6).</p> <p>Findings include</p> <p>1. The agency's policy titled "Documentation Standards and Guidelines," no number, no date, stated "Procedure: ... 2. Current: Timely documentation, as near to the time of occurrence as feasible. Entire are always dated when they were made, i.e. no backdating."</p> <p>2. The agency's policy titled "Electronic Charting," no number, no date, stated "Staff must document prior to leaving clients home and have documentation in "ready to review" status within 24 hours. ... Nursing staff will have the ability to electronically chart in the home. It is</p>	N 0544	<p>A. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. B. 1. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. B. 2. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit</p>	07/15/2016

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	<p>expected that all documentation be completed prior to leaving the client's home at the end of the shift. Documentation will be reviewed by an Administrative RN and will be "rejected" to the documenting field nurse as needed for correction. The filed nurse will then have 24 hours to correct and resubmit any documentation."</p> <p>3. The clinical record for patient # 4 was reviewed on 6/20/16. Start of care date 2/9/16. The initial start of care assessment completed by employee C, RN, failed to evidence it was electronically signed until 2/18/16, 9 days post start of care.</p> <p>A. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>*** The clinical record for patient # 5 was reviewed on 6/20/16. Start of care date 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for HHA services. The record failed to evidence the electronic RN visit notes were completed in a timely manner.</p> <p>A. The electronic recertification visit</p>		<p>notes on an ongoing basis to ensure continued compliance with this requirement. The Administrator will be responsible for ongoing compliance with N0544.</p>		

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	<p>note dated 5/5/15 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>4. The clinical record for patient # 6 was reviewed on 6/15/16. Start of care date 12/28/13. The record failed to evidence timely submission of electronic visit notes.</p> <p>A. The SN visit dated 5/6/16 by employee G (RN) was not signed until 6/7/16.</p> <p>B. The SN visit dated 5/27/16 by employee G was not signed until 6/7/16.</p> <p>5. The clinical record for patient # 9 was reviewed on 6/17/16. Start of care date 12/9/13. The patient was discharged on 1/5/16 to long term care. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary was not completed until 3/2/16, and failed to include a summary of care provided.</p> <p>A. During interview on 6/16/16 at 12:30 PM, the Nursing Supervisor stated she was not here at that time, so she is not sure why the discharge summary for patient #9 was not completed until March, but the discharge summaries are to include a summary of care provided, per agency policy.</p>			

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N 0596 Bldg. 00	<p>6. The clinical record for patient # 10 was reviewed on 6/16/17. Start of care 12/6/13. The patient was discharged to home per patient and care giver request on 2/2/16. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary failed to include a summary of care provided.</p> <p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on document review and interview the agency failed to ensure 3 of 4 HHA files contained a copy of the HHA competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA competency</p>	N 0596	A. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B. Agency will complete home	07/15/2016

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	<p>test.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p>		<p>health aide competency evaluation program prior to patient contact. (For a period of two years beginning June 21, 2016, this competency evaluation program will be conducted by an independent outside provider as Home Healthcare Associates is prohibited from providing said program during that time frame.) The Agency will ensure continuing compliance by auditing 100% of employee files for presence of HHA written competency evaluation prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. The Administrator is responsible for ensuring ongoing compliance with N0596.</p>	

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N 0597 Bldg. 00	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H) prior to providing care to patients.</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager)</p>	N 0597	<p>A. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. B. The Agency will ensure that HHA is active on registry prior to patient contact. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact for current HHA certification until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. The Administrator is responsible for ensuring ongoing compliance with N0597.</p>	07/15/2016

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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	<p>stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure o the part of the employee to provide this document will relive Home Healthcare Associates of any employment obligations. The employee will be considered unable to</p>			

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N 0598 Bldg. 00	<p>perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p> <p>3. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meet the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p>			

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	<p>Based on document review and interview the agency failed to ensure 1 of 4 Home Health Aides (HHA) had an active certification and was on the Indiana Nurse Aide Registry (H) prior to providing care to patients.</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2</p>	N 0598	<p>A. Agency audited 100% of employee files for compliance with HHA certification. 100% of current employees were found to have current HHA certification. B. The Agency will ensure that HHA is active on registry prior to patient contact. Agency will ensure continuing compliance by auditing 100% of employee files prior to patient contact for current HHA certification until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. The Administrator is responsible for ensuring ongoing compliance with N0598.</p>	07/15/2016

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	<p>patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. The agency's policy titled "Current Licensure/Certification and Registration," no number, no date, stated "Procedure: At time of employment: All newly hired employees, whose job requires licensure by the state or other proof of registry or certification will provide the original document before the employee may assume duties associated with such a license. Failure o the part of the employee to provide this document will relive Home Healthcare Associates of any employment obligations. The employee will be considered unable to perform duties of the job requiring the documents, or the date of hire will be adjusted to reflect the date the document is received. ... The following procedure will be followed to assure current status: At the time of hire and at time of relicensure/recertification a photocopy of</p>			

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N 0600 Bldg. 00	<p>the document is received in Human Resources. License/certification monitoring is the responsibility of the Administrator and communicated to the Nursing Supervisor."</p> <p>3. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "Purpose: To comply with Medicaid/Medicare guidelines, Ensure the HHA meet the qualifications for a HHA and are appropriately registered on the Aide Registry. ... Policy: ... All Home Health Aides will be registered with the Indiana Professional Licensing Board and be in good standing."</p> <p>410 IAC 17-14-1(l)(3) Scope of Services Rule 14 Sec. 1(l)(3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not the employing agency, the employing agency shall keep a copy of the competency evaluation documentation in the home health aide's employment file. Based on document review and interview the agency failed to ensure 3 of 4 HHA files contained a copy of the HHA</p>	N 0600	A. Agency audited 100% of employee files for compliance with written competency evaluations. Home Health Aides	07/15/2016

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	<p>competency test (E, F, and H).</p> <p>Findings include</p> <p>1. Employee file H was reviewed on 6/20/16. Employee H was listed as a HHA, with date of hire 5/17/16 and first patient contact date 6/7/16. The file failed to evidence a HHA certification, failed to evidence a HHA competency test. The file contained a partially completed Home Health Aide Registry Application signed by the employee on 5/17/16 stating the employee "completed a competency evaluation programs required by this regulation;" this form failed to evidence it was completed and signed by the Registered Nurse and the Administrator.</p> <p>A. During interview on 6/20/16 at 10:30 AM, employee I (Office Manager) stated this employee's HHA number expired so the agency had to do an application to the Indiana Nurse Aide registry but they had not sent it in yet, and the test is probably with other missing items. Employee I stated this aide has been providing care for 2 patients since 6/7/16.</p> <p>B. A check of the Indiana Professional Licensing Agency website on 6/20//16 at 11:40 AM evidenced employee H's HHA</p>		<p>that did not have a written competency evaluation were given the written competency evaluation, 100% of the Home Health Aides given the written competency evaluation passed the exam, and 100% of current employees were found to have current HHA written examination results in their employee file. B. The Agency will ensure home health aide competency evaluation program is complete prior to patient contact. (For a period of two years beginning June 21, 2016, this competency evaluation program will be conducted by an independent outside provider as Home Healthcare Associates is prohibited from providing said program during that time frame.) The Agency will ensure continuing compliance by auditing 100% of employee files for presence of HHA written competency evaluation prior to patient contact until 100% compliance has been achieved for 6 months, and then 10% of all employee files will be audited for compliance with this standard prior to patient contact. The Administrator is responsible for ensuring ongoing compliance with N0600.</p>				

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N 0606 Bldg. 00	<p>certification had expired on 11/21/15.</p> <p>C. On 6/21/16 at 11:15 AM, the Daily Notes for patients # 15 and 16 were provided. These notes evidenced employee H provided care on 6/7, 8, 9, and 10, 2016 for both patients.</p> <p>2. Employee file E, HHA, was reviewed on 6/01/16. Date of hire 5/25/16, first patient contact date 5/26/16. This file failed to evidence a HHA competency test.</p> <p>3. Employee file F, HHA, was reviewed on 6/20/16. Date of hire 12/6/13, first patient contact date 12/17/13. This file failed to evidence a HHA competency test.</p> <p>4. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Qualifications: ... Must have taken passed the Certified Home Health Aide Test."</p> <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</p>			

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	<p>(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 observation, document review, and interview, the agency failed to ensure the registered nurse supervised the home health aide (HHA) to ensure they did not administer a prescription medication in 1 of 5 home visits of HHA observations (# 3); and failed to ensure the supervision of HHAs every 2 weeks for 1 of 2 records reviewed of patients receiving HHA and skilled services (#6).</p> <p>Findings include</p> <p>1. During home visit observation on 6/16/16 at 12:30 PM, employee E (HHA) was observed providing care to patient # 3. Employee E was observed applying Lac-Hydrin 12% lotion to the patient's back, and legs. The bottle contained a prescription label which read "Lac-Hydrin 12 % Ammonium Lactate, daily to dry skin and PRN (as needed)." Patient # 3 lives in a group home.</p> <p>A. The plan of care dated 6/6-8/4/16 contained diagnoses of Profound Intellectual Disabilities and Cerebral Palsy. The medication section listed the lotion: Lac-Hydrin 12 % topical apply to dry skin daily as needed."</p>	N 0606	<p>A. 1. Agency educated all clinical staff on the policy regarding Home Health Aides and the administration of medication with specific attention to medicated lotions. A. 2. Agency will ensure continued compliance by unannounced site visits to ensure compliance until 100% compliance is achieved for 6 months, and then ongoing surveillance via unannounced site visits will be conducted to ensure continued compliance with standard. The Director of Nursing is responsible for ensuring ongoing compliance with N0606.</p>	07/15/2016

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	<p>B. The Home Health Aide Care plan printed 6/14/16 failed to evidence medication assistance was tasked for the HHA.</p> <p>C. During interview on 6/16/16 at 2:40 PM, employee B (Nursing Supervisor/Alternate Administrator) stated if a HHA is checked off for medication assistance, they are allowed to assist with self-application, and the agency's consultant told us if it's on the medication list and part of personal care, the HHA can apply it. The Nursing Supervisor stated otherwise the group home staff need to do it.</p> <p>2. The agency's policy titled "Certified Home Health Aide Services/Supervision," no number, no date, stated "The Home Health Aide (HHA) will only provide services within their designated scope of practice ... Supervisory Practice: If the patient receives skilled nursing care, the registered nurse will perform the supervisory visit no less than every 2 weeks."</p> <p>4. The agency's job description titled "Certified Home Health Aide," no number, no date, stated "Essential Duties and Responsibilities: ... Reminds client to take prescribed medications as direct</p>			

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N 0608 Bldg. 00	<p>by physician or home care nurse."</p> <p>5. The agency's policy titled "Medication assistance by HHA/Attendant Caregivers," no number, no date, stated "Medication assistance means "the provision of assistance through reminders or cues to take the medication, the opening of pre-set medication containers, and providing assistance in the handling or ingesting of non-controlled substance medications, including ... over-the-counter medications; and to an individual who is unable to accomplish the task due to an impairment and who is either competent and has directed the services or is incompetent and has the services directly by a competent individual who may consent it health care for the impaired individual." Procedures: Home Health Aides ... may assist patients with medication in the manner listed above as instructed by the Supervising Nurse."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and</p>			

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	<p>appropriate identifying information.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on document review and interview, the agency failed to ensure the Registered Nurse (RN) prepared discharge summaries to include care provided for 2 of 4 discharge records reviewed (# 9, and 10); failed to ensure discharge summaries were completed within 30 days of discharge for 1 of 4 discharge records reviewed (# 9); failed to ensure Home Health Aides (HHA) and RNs completed visit notes in a timely manner and according to agency policy for 8 of 10 clinical records reviewed (# 2, 3, 4, 5, 6, 8, 9 and 10); failed to ensure consent for services was signed prior to providing care for 1 of 10 clinical records reviewed (# 7); and failed to ensure the Registered Nurse collected Outcome Assessment and Information Set (OASIS) data on start of care and failed to ensure the information was completed within 5 days of start of care for 1 of 4 records reviewed of patients receiving skilled</p>	N 0608	<p>A. The agency will complete all discharge summaries within 30 days of discharge for all discharged patients. B. 1. Upon review of the policy and in light of the technological difficulties, which include lack of internet access in the field, that make compliance impossible with the previous policy that required employees to submit documentation in ready-for-review status within 24 hours, the Agency has revised the policy to include a 72 hour time frame for completion and transmission of visit notes. B. 2. The agency will have all visit notes in ready-for-review status within 72 hours of patient visit. C. The Agency audited 100% of patient charts to determine the presence of consents. Consents were found on 100% of current patient charts. E. The Agency will complete patient consents prior to provision of services. F. The Agency will transmit all</p>	07/15/2016

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	<p>services. (#8)</p> <p>Findings include</p> <p>1. The agency's policy titled "Documentation Standards and Guidelines," no number, no date, stated "Procedure: ... 2. Current: Timely documentation, as near to the time of occurrence as feasible. Entries are always dated when they were made, i.e. no backdating."</p> <p>2. The agency's policy titled "Electronic Charting," no number, no date, stated "Staff must document prior to leaving clients home and have documentation in "ready to review" status within 24 hours. ... Nursing staff will have the ability to electronically chart in the home. It is expected that all documentation be completed prior to leaving the client's home at the end of the shift. Documentation will be reviewed by an Administrative RN and will be "rejected" to the documenting field nurse as needed for correction. The filed nurse will then have 24 hours to correct and resubmit any documentation."</p> <p>3. The agency's policy titled "Patient Discharge (Summary)," no number, no date, stated "All patient discharge summaries must be complete within 30</p>		<p>available OASIS data to the state agency monthly and within 30 days after the assessment is completed. G. The Agency will monitor and review final validation reports and correct errors. H. The Agency will ensure all OASIS data submitted is not rejected. I. The Agency will ensure correction of rejected data. J. The Agency will ensure error reports are monitored. The Agency will audit 100% of discharge summaries until 100% compliance is maintained for a period of 6 months to ensure all discharge summaries are completed and sent to physician within 30 days. After that the Agency will continue to audit 10% of the discharge summaries on an ongoing basis to ensure continued compliance with this requirement. The Agency will audit 100% of visit notes until 100% compliance is maintained for a period of 6 months to ensure all visit notes are in ready-for-review status within 72 hours. After that the Agency will continue to audit 10% of the visit notes on an ongoing basis to ensure continued compliance with this requirement. Agency will continue to audit 100% of patient charts for compliance with obtaining consents prior to provision of services until 100% compliance has been achieved for 6 months and then agency will continue to audit 10% of all patient charts to determine ongoing compliance</p>	

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	<p>days of discharge. ... The discharge summary should include: ... Summary of care provided ... The discharge summary and other relevant clinical record documents will be completed and submitted to the organization within seven days of discharge from the agency. ... The agency will complete all necessary audits to determine the completeness of the patient's clinical record within thirty days of the last home visit and discharge date."</p> <p>4. During interview on 6/14/16 at 10:30 AM, the Administrator stated the agency allows 7 days for documents to be filed within the patient records if they are paper charting, but electronic notes should be synced to the computer daily.</p> <p>5. The clinical record for patient # 2 was reviewed on 6/17/16. Start of care date 3/10/16. The plan of care dated 5/9-7/7/16 contained orders for HHA services. The record failed to evidence the electronic HHA visit notes were completed in a timely manner.</p> <p>A. The electronic HHA Visit Note dated 5/29/16 by employee J (HHA) was not signed until 6/15/16, 17 days after the visit.</p> <p>B. The electronic HHA Visit Note</p>		<p>with standard. The Agency will audit 100% of all OASIS assessments for timeliness of submission until 100% compliance is achieved for 6 months. After that the Agency will continue to audit 10% of all OASIS assessments to ensure continued compliance with this requirement. The Agency will audit 100% of all OASIS reports to monitor and review final validation reports and correct errors and ensure all OASIS data submitted is not rejected to ensure timeliness, to ensure accuracy, to ensure correction of rejected OASIS data until 100% compliance has been achieved for 6 months. After that, the Agency will continue to audit 10% of the OASIS final validation reports to ensure continued compliance with this requirement. The Administrator is responsible for ensuring ongoing compliance with N0608.</p>	

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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	<p>dated 5/30 by employee K (HHA) was not signed until 6/15/16, 16 days after the visit.</p> <p>C. The electronic HHA Visit Note dated 5/13 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>D. The electronic HHA Visit Note dated 5/11 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>E. The electronic HHA Visit Note dated 5/9 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>F. The electronic HHA Visit Note dated 5/6 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>G. The electronic HHA Visit Note dated 5/4 by employee K was not signed until 6/15/16, over 30 days after the visit.</p> <p>H. During interview on 6/17/16 at 1:25 PM, the Nursing Supervisor stated employee K is out of compliance with documentation, that aide is not the only one, but the agency has not had a chance to talk with employee K about this as she is not returning their phone calls. The Nursing Supervisor stated the agency has been short staffed and not been able to properly provide for discipline and</p>			

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	<p>corrections.</p> <p>I. During interview on 6/17/16 at 1:25 PM, employee I (Office Manager) stated employee K is off the schedule.</p> <p>6. The clinical record for patient # 3 was reviewed on 6/17/16. Start of care 12/19/13. The plan of care dated 4/7-6/5/16 contained orders for HHA services. The record failed to evidence the electronic HHA visit notes were completed in a timely manner.</p> <p>A. The electronic HHA Visit Note dated 4/9/16 by employee K was not signed until 4/19/16, over 10 days after the visit.</p> <p>7. The clinical record for patient # 4 was reviewed on 6/20/16. Start of care date 2/9/16. The plan of care dated 4/9-6/7/16 contained orders for HHA services. The record failed to evidence the electronic HHA notes and RN visit notes were completed in a timely manner.</p> <p>A. The initial start of care assessment completed by employee C, RN, failed to evidence it was electronically signed until 2/18/16, 9 days post start of care.</p> <p>B. The electronic HHA note dated 6/2/16 by employee L (HHA) was not</p>			

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	<p>signed until 6/12/16, 10 days after the visit.</p> <p>C. The electronic HHA note dated 5/31/16 by employee L was not signed until 6/6/16, 6 days after the visit.</p> <p>D. The electronic HHA note dated 5/19/16 by employee L was not signed until 5/25/16, 5 days after the visit.</p> <p>E. The electronic HHA note dated 5/18/16 by employee L was not signed until 5/25/16, 7 days after the visit.</p> <p>F. The electronic HHA note dated 5/17/16 by employee L was not signed until 5/25/16, 8 days after the visit.</p> <p>G. The electronic HHA note dated 5/10/16 by employee L was not signed until 5/15/16, 5 days after the visit.</p> <p>H. The electronic HHA note dated 5/9/16 by M (HHA) was not signed until 5/16/16, 7 days after the visit.</p> <p>I. The electronic HHA note dated 5/5/16 by employee L was not signed until 5/15/16, 10 days after the visit.</p> <p>J. The electronic HHA note dated 5/4/16 by employee L was not signed until 5/15/16, 11 days after the visit.</p>			

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	<p>K. The electronic HHA note dated 5/3/16 by employee L was not signed until 5/15/16, 12 days after the visit.</p> <p>L. The electronic HHA note dated 4/22/16 by employee N (HHA) was not signed until 4/28/16, 6 days after the visit.</p> <p>M. The electronic HHA note dated 4/21/16 by employee N was not signed until 4/28/16, 7 days after the visit.</p> <p>8. The clinical record for patient # 5 was reviewed on 6/20/16. Start of care date 7/18/14. The plan of care dated 5/8-7/6/16 contained orders for HHA services. The record failed to evidence the electronic HHA and RN visit notes were completed in a timely manner.</p> <p>A. The electronic recertification visit note dated 5/5/15 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>B. The electronic HHA note dated 5/10/16 by employee O (HHA) was not signed until 5/14/16, 4 days after the visit.</p> <p>C. The electronic HHA note dated 5/12/16 by employee P (HHA) was not signed until 5/16/16, 6 days after the</p>			

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	<p>visit.</p> <p>D. The electronic HHA note dated 5/13/16 by employee P was not signed until 5/16/16, 3 days after the visit.</p> <p>E. The electronic HHA note dated 5/19/16 by employee P was not signed until 5/24/16, 5 days after the visit.</p> <p>F. The electronic HHA note dated 5/20/16 by employee P was not signed until 5/24/16, 4 days after the visit.</p> <p>G. The electronic HHA note dated 5/27/16 by employee P was not signed until 5/31/16, 4 days after the visit.</p> <p>H. The electronic HHA note dated 5/30/16 by employee O, a missed visit, was not signed until 6/15/16, 16 days post missed visit.</p> <p>I. The electronic HHA note dated 6/3/16 by employee P was not signed until 6/8/16, 5 days after the visit.</p> <p>J. The electronic HHA note dated 6/2/16 by employee P was not signed until 6/8/16, 6 days after the visit.</p> <p>9. The clinical record for patient # 6 was reviewed on 6/15/16. Start of care date 12/28/13. The record failed to evidence</p>			

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	<p>timely submission of electronic visit notes.</p> <p>A. The SN visit dated 5/6/16 by employee G (RN) was not signed until 6/7/16.</p> <p>B. The SN visit dated 5/27/16 by employee G was not signed until 6/7/16.</p> <p>10. The clinical record for patient #7 was reviewed on 6/17/16. Start of care date 9/22/14. The record failed to evidence the patient had signed a consent for services form and failed to evidence the agency retained notification of patient rights for this admission.</p> <p>A. During interview on 6/17/16, at 11:30 AM, the Alternate Administrator stated she could not find the consent for services for 9/22/14.</p> <p>11. The clinical record for patient # 8 was reviewed on 6/17/16. Start of care date 4/8/16. The plan of care dated 4/8-6/6/16 contained orders for SN every 2 weeks for 8 weeks, and 2 PRN for medication set up, change in in condition, and recertification; beginning week of 4/12/16 SN to assess and evaluate 4/8-4/10/16. The record failed to evidence the electronic RN and HHA visit notes were completed in a timely</p>			

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	<p>manner, and failed to evidence the RN collected OASIS data on admission or within 5 days of start of care.</p> <p>A. The Initial Evaluation RN visit note dated 4/11/16 by employee C failed to evidence the initial start of care assessment included OASIS data, and failed to evidence a reason the visit was not completed until 4/11/16. Employee C failed to electronically sign this document until 4/15/16, 4 days after the visit.</p> <p>B. The SN Visit note dated 5/4/16 by employee C was not signed until 5/9/16, 4 days after the visit.</p> <p>C. During interview on 6/17/16 at 10:10 AM, the Nursing Supervisor stated the start of care OASIS information is not showing up in the computer, but there is not a way to do any other OASIS assessments without one in the computer. The Nursing Supervisor stated there is not a reason in the computer as to why the RN did not assess for start of care until 4/11/16.</p> <p>12. The clinical record for patient # 9 was reviewed on 6/17/16. Start of care date 12/9/13. Discharge date 1/5/16 to long term care. The Discharge Summary was not completed until 3/2/16 and failed</p>			

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	<p>to include a summary of care provided. The Discharge Summary section titled "Summary/Notes" is blank.</p> <p>A. The Discharge Summary section titled "Summary/Notes" is blank.</p> <p>B. During interview on 6/16/16 at 12:30 PM, the Nursing Supervisor stated she was not here at that time, so she is not sure why the discharge summary for patient #9 was not completed until March, but the discharge summaries are to include a summary of care provided, per agency policy.</p> <p>13. The clinical record for patient # 10 was reviewed on 6/16/17. Start of care 12/6/13. The patient was discharged to home per patient and care giver request on 2/2/16. The Discharge Summary section titled "Summary/Notes" is blank. The Discharge Summary failed to include a summary of care provided.</p> <p>14. The agency's policy titled "OASIS Reporting and Comprehensive Assessment," no number, no date, stated "Home Healthcare Associates will comply with State and federal guidelines with regards to OASIS data collection and reporting. ... Comprehensive Assessment: (to include the administration of the OASIS) Each</p>			

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	patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status ... This assessment (start of care) will be completed by a registered nurse in a timely manner, consistent with patient's immediate needs, but no later than 5 calendar days from the start of care. ... The Comprehensive Assessment will incorporate the use of current OASIS items."			