

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2013
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NAME OF PROVIDER OR SUPPLIER CAREGIVERS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3536 WASHINGTON BLVD INDIANAPOLIS, IN 46205
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G000000	<p>This visit was a Federal Home Health complaint investigation survey.</p> <p>Complaint number: IN00131226 - Substantiated: Federal deficiency related to the allegations is cited. Unrelated deficiencies are also cited.</p> <p>Survey dates: August 5, 2013</p> <p>Facility number: 005941</p> <p>Medicaid Vendor Number: 100265760A</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 9, 2013</p>	G000000		

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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G000111	<p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA.</p> <p>Based on clinical record review and interview, the agency failed to ensure patient records kept at another agency were kept confidential in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services for the agency. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Patient #1, SOC 9/12/12, record contained a plan of care for the certification period of 5/10/13 to 7/8/13. The record evidenced there were missed HHA visits on 6/15/13, 6/16/13, 6/17/13, and 6/18/13. The record failed to evidence missed visit notes. 2. During an interview on 8/5/13 at 4:30 PM, Employee B, Quality Assurance, indicated that Employee A, HHA, did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the missed HHA visits were not in the patient's chart. Employee B further indicated that another agency would have copies of the HHA visits in their 	G000111	<p>G 111 and N 441 Confidentiality of Medical Records -= failure to ensure patient records kept at another agency were kept confidential.</p> <p>C1. Clinical Operations/designee has completed disciplinary counseling to this contracted agency (CG2) in their failure to submit clinic documentation in timely manner</p> <p>C2. In the future, contracted agency (CG2) will follow Home Health Aide Documentation Policy, stating the original documentation shall be filed in the clinical record with in fourteen (14) days of the end of the recording period.</p> <p>C3. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and clinical documentation records are being communicated appropriately and timely.</p> <p>C4. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is</p>	08/14/2013	

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	files, but the other agency would need to fax those to Caregivers. The missed HHA visits were not faxed over by Exit Conference.		corrected and will not recur.		

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G000124	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION Administrative and supervisory functions are not delegated to another agency or organization.</p> <p>Based on clinical record review and interview, the agency failed to ensure patient records were kept within the agency in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services for the agency. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Patient #1, SOC 9/12/12, record contained a plan of care for the certification period of 5/10/13 to 7/8/13. The record evidenced there were missed HHA visits on 6/15/13, 6/16/13, 6/17/13, and 6/18/13. The record failed to evidence missed visit notes. 2. During an interview on 8/5/13 at 4:30 PM, Employee B, Quality Assurance, indicated that Employee A, HHA, did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the missed HHA visits were not in the patient's chart. Employee B further indicated that another agency with 	G000124	<p>G 124 - N 508 Organizations, Services & Administration – failure to ensure patient records were kept within the agency. C1. Clinical Operations/designee has completed disciplinary counseling to this contracted agency (CG2) in their failure to submit clinic documentation in timely manner C2. In the future, contracted agency (CG2) will follow Home Health Aide Documentation Policy, stating the original documentation shall be filed in the clinical record with in fourteen (14) days of the end of the recording period. C3. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and clinical documentation records are being communicated appropriately and timely. C4. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	08/14/2013

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	whom they contracted would have copies of the HHA visits in their files, but the other agency would need to fax those to Caregivers. The missed HHA visits were not faxed over by Exit Conference.			

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy review, record review, and interview, the agency failed to ensure visits were provided as ordered in 1 of 3 Home Health Aide (HHA) records and 1 of 3 Physical Therapy (PT) records reviewed with the potential to affect all patients of the agency who receive HHA and PT services (#1, #3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The agency policy titled "Clinical Documentation" policy #C-680 undated states, "Services not provided and the reason for the missed visits will be documented and reported to the physician." Patient #1, SOC 9/12/12, record contained a certification period of 5/10/13 to 7/8/13 with orders for Home Health Aide (HHA) 1 time a week for 1 week, 5 hour duration and 7 times a week for 8 weeks, 5 hour duration. The record evidenced the following: 	G000158	<p>G 158 and N 522 Follows a written POC. Correction Response: Failure to ensure visits were provided as ordered.</p> <p>C1. The Clinical Operation Manage/designee will in services all of staff beginning 08/14/13, that all missed visit must be communicated to the Physician in a timely manner, with the reason why the visit was missed. The missed visit form must be completed in its entirety by each discipline and communicated to the physician by phone, mail or fax. Identify in the disciplines' note that a visit was either refused or the patient had a doctor's appointment. Completion of all staff in services by 08/30/13.</p> <p>C2. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and visit frequencies are being communicated appropriately and timely.</p> <p>C3. The Clinical Operations</p>	08/14/2013			

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	<p>A. The Home Health Aide Care Plan last dated and signed off or initialed by the Registered Nurse (RN) on 3/8/13 contained an order for the HHA to visit patient 7 times a week for two visits of 2 hour duration and one 1 hour visit for a total of 5 hours daily.</p> <p>B. The Home Health Aide Daily Activity Record failed to evidence HHA visits 6/15/13 to 6/18/13.</p> <p>C. The record evidenced the patient was taken to the hospital Emergency Room by the spouse for decreased intake and chest pain on 6/18/13. The hospital assessed the patient and indicated the patient presented at the hospital with dried food under her breast, dried stool between her legs, and her Foley catheter crusted.</p> <p>D. During an interview on 8/5/13 at 4:30 PM, Employee B, Quality Assurance, indicated that Employee A, HHA, did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the documentation was not in Patient #1's chart. Employee B further indicated that another home health agency would have copies of the HHA visits in their files, but they would need to fax those to Caregivers. The missed HHA visits were</p>		<p>Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>not faxed over by Exit Conference.</p> <p>3. Patient #3, SOC 6/1/13, record contained a certification period of 6/1/13 to 7/30/13 with orders for Physical Therapy (PT) 1 time a week for 1 week and 2 times a week for 3 weeks. The record evidenced PT visited Patient #3 on 6/13/13, and a Missed Visit Report was filled out for 6/20/13. The record failed to evidence a PT visit or Missed Visit Report for 6/15/13, 6/16/13, 6/17/13, 6/18/13, and 6/19/13.</p> <p>During an interview on 8/5/13 at 3:35 PM, Employee E, Administrator, indicated patient #3 refused further PT visits due to language barrier. Employee E indicated there wasn't any PT Missed Visits in the chart for 6/15/13, 6/16/13, 6/17/13, 6/18/13, and 6/19/13.</p>			

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G000224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Home Health Aide (HHA) plan of care was updated at least every 60 days as required by agency policy in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency policy titled "Home Health Aide Care Plan" policy #C-751 undated states, "The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse as often as necessary, but minimally every sixty (60) days as part of the physician's Plan of Care (485). The Care Plan, itself, does not require a signature." Patient #1, SOC 9/12/12, record contained a plan of care for the certification period of 5/10/13 to 7/8/13 	G000224	<p>G 224 - N 550 Scope of Services – failure to ensure the Home Health Aide (HHA) plan of care was updated at least every 60 days as required.</p> <p>C1. Clinical Operations/designee will in services of all staff beginning 08/14/13, for completion of the Home Health Aide Care Plans shall be reviewed and updated by the RN as often as necessary, but at least every 60 days as part of the POC.</p> <p>C2. Beginning immediately chart audits will be completed every 60 days or at discharge for evidence that Home Health Aide documentation and Care Plan are being followed.</p> <p>C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency</p>	08/14/2013			

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	<p>with orders for Home Health Aide (HHA) 1 time a week for 1 week, 5 hour duration and 7 times a week for 8 weeks, 5 hour duration. The record evidenced the Home Health Aide Care Plan last dated and signed off or initialed by the Registered Nurse (RN) on 3/8/13 contained an order for the HHA to visit patient 7 times a week for two 2 hour visits and one 1 hour visit. The document failed to evidence a RN signature or initial for the 5/10/13 to 7/8/13 certification period.</p> <p>3. During an interview on 8/5/13 at 2:15 PM, Employee B, Quality Assurance, indicated that the Home Health Aide Care Plan should have been signed or initialed and updated by the RN every 60 days.</p>			

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N000000	<p>This visit was a state Home Health complaint investigation survey.</p> <p>Complaint number: IN00131226 - Substantiated: State deficiency related to the allegation is cited. Unrelated deficiencies are also cited.</p> <p>Survey dates: August 5, 2013</p> <p>Facility number: 005941</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 9, 2013</p>	N000000			

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N000441	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency.</p> <p>Based on clinical record review and interview, the agency failed to ensure services provided by another agency were controlled by the agency in that patient records were stored at another agency in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services for the agency. (#1)</p> <p>The findings include:</p> <p>1. Patient #1, SOC 9/12/12, record contained a certification period of 5/10/13 to 7/8/13. The record evidences the following:</p> <p>There were missed HHA visits on 6/15/13, 6/16/13, 6/17/13, and 6/18/13. The record failed to evidence missed visit notes.</p> <p>2. During an interview on 8/5/13 at 4:30</p>	N000441	<p>G 111 and N 441 Confidentiality of Medical Records -= failure to ensure patient records kept at another agency were kept confidential.</p> <p>C1. Clinical Operations/designee has completed disciplinary counseling to this contracted agency (CG2) in their failure to submit clinic documentation in timely manner</p> <p>C2. In the future, contracted agency (CG2) will follow Home Health Aide Documentation Policy, stating the original documentation shall be filed in the clinical record with in fourteen (14) days of the end of the recording period.</p> <p>C3. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and clinical documentation records are being communicated appropriately and timely.</p> <p>C4. The Clinical Operations</p>	08/14/2013			

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	PM, Employee B, Quality Assurance, indicated that Employee A, HHA did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the missed HHA visits were not in the patient's chart. Employee B further indicated that Caregivers 2 would have copies of the HHA visits in their files, but Caregivers 2 would need to fax those to Caregivers. The missed HHA visits were not faxed over in time for Exit Conference.		Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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N000508	<p>410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p> <p>Based on clinical record review and interview, the agency failed to ensure patient records kept at another agency were kept confidential in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services for the agency. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Patient #1, SOC 9/12/12, record contained a plan of care for the certification period of 5/10/13 to 7/8/13. The record evidenced there were missed HHA visits on 6/15/13, 6/16/13, 6/17/13, and 6/18/13. The record failed to evidence missed visit notes. 2. During an interview on 8/5/13 at 4:30 PM, Employee B, Quality Assurance, 	N000508	<p>G 124 - N 508 Organizations, Services & Administration – failure to ensure patient records were kept within the agency.</p> <p>C1. Clinical Operations/designee has completed disciplinary counseling to this contracted agency (CG2) in their failure to submit clinic documentation in timely manner</p> <p>C2. In the future, contracted agency (CG2) will follow Home Health Aide Documentation Policy, stating the original documentation shall be filed in the clinical record with in fourteen (14) days of the end of the recording period.</p> <p>C3. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and clinical</p>	08/14/2013			

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	indicated that Employee A, HHA, did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the missed HHA visits were not in the patient's chart. Employee B further indicated that another agency would have copies of the HHA visits in their files, but the other agency would need to fax those to Caregivers. The missed HHA visits were not faxed over by Exit Conference.		documentation records are being communicated appropriately and timely. C4. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on policy review, record review, and interview, the agency failed to ensure visits were provided as ordered in 1 of 3 Home Health Aide (HHA) records and 1 of 3 Physical Therapy (PT) records reviewed with the potential to affect all patients of the agency who receive HHA and PT services (#1, #3).</p> <p>Findings include:</p> <p>1. The agency policy titled "Clinical Documentation" policy #C-680 undated states, "Services not provided and the reason for the missed visits will be documented and reported to the physician."</p> <p>2. Patient #1, SOC 9/12/12, record contained a certification period of 5/10/13 to 7/8/13 with orders for Home Health Aide (HHA) 1 time a week for 1 week, 5 hour duration and 7 times a week for 8 weeks, 5 hour duration. The record evidenced the following:</p>	N000522	<p>G 158 and N 522 Follows a written POC. Correction Response: Failure to ensure visits were provided as ordered.</p> <p>C1. The Clinical Operation Manage/designee will in services all of staff beginning 08/14/13, that all missed visit must be communicated to the Physician in a timely manner, with the reason why the visit was missed. The missed visit form must be completed in its entirety by each discipline and communicated to the physician by phone, mail or fax. Identify in the disciplines' note that a visit was either refused or the patient had a doctor's appointment. Completion of all staff in services by 08/30/13.</p> <p>C2. Beginning immediately weekly missed visit reports will be ran and reconciled and that missed visit and visit frequencies are being communicated appropriately and timely.</p> <p>C3. The Clinical Operations</p>	08/14/2013	

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	<p>A. The Home Health Aide Care Plan last dated and signed off or initialed by the Registered Nurse (RN) on 3/8/13 contained an order for the HHA to visit patient 7 times a week for two visits of 2 hour duration and one 1 hour visit for a total of 5 hours daily.</p> <p>B. The Home Health Aide Daily Activity Record failed to evidence HHA visits 6/15/13 to 6/18/13.</p> <p>C. The record evidenced the patient was taken to the hospital Emergency Room by the spouse for decreased intake and chest pain on 6/18/13. The hospital assessed the patient and indicated the patient presented at the hospital with dried food under her breast, dried stool between her legs, and her Foley catheter crusted.</p> <p>D. During an interview on 8/5/13 at 4:30 PM, Employee B, Quality Assurance, indicated that Employee A, HHA, did in fact visit the patient on 6/15/13 through 6/18/13. Employee B acknowledged the documentation was not in Patient #1's chart. Employee B further indicated that another home health agency would have copies of the HHA visits in their files, but they would need to fax those to</p>		<p>Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>Caregivers. The missed HHA visits were not faxed over by Exit Conference.</p> <p>3. Patient #3, SOC 6/1/13, record contained a certification period of 6/1/13 to 7/30/13 with orders for Physical Therapy (PT) 1 time a week for 1 week and 2 times a week for 3 weeks. The record evidenced PT visited Patient #3 on 6/13/13, and a Missed Visit Report was filled out for 6/20/13. The record failed to evidence a PT visit or Missed Visit Report for 6/15/13, 6/16/13, 6/17/13, 6/18/13, and 6/19/13.</p> <p>During an interview on 8/5/13 at 3:35 PM, Employee E, Administrator, indicated patient #3 refused further PT visits due to language barrier. Employee E indicated there wasn't any PT Missed Visits in the chart for 6/15/13, 6/16/13, 6/17/13, 6/18/13, and 6/19/13.</p>			

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Home Health Aide (HHA) plan of care was updated at least every 60 days as required by agency policy in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving HHA services. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency policy titled "Home Health Aide Care Plan" policy #C-751 undated states, "The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse as often as necessary, but minimally every sixty (60) days as part of the physician's Plan of Care (485). The Care Plan, itself, does not require a signature." Patient #1, SOC 9/12/12, record contained a plan of care for the 	N000550	<p>N 550 Scope of Services – failure to ensure the Home Health Aide (HHA) plan of care was updated at least every 60 days as required.</p> <p>C1. Clinical Operations/designee will in services of all staff beginning 08/14/13, for completion of the Home Health Aide Care Plans shall be reviewed and updated by the RN as often as necessary, but at least every 60 days as part of the POC.</p> <p>C2. Beginning immediately chart audits will be completed every 60 days or at discharge for evidence that Home Health Aide documentation and Care Plan are being followed.</p> <p>C3. The Clinical Operations Manager/designee will be responsible for monitoring these corrective actions to ensure that this deficiency</p>	08/14/2013

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	<p>certification period of 5/10/13 to 7/8/13 with orders for Home Health Aide (HHA) 1 time a week for 1 week, 5 hour duration and 7 times a week for 8 weeks, 5 hour duration. The record evidenced the Home Health Aide Care Plan last dated and signed off or initialed by the Registered Nurse (RN) on 3/8/13 contained an order for the HHA to visit patient 7 times a week for two 2 hour visits and one 1 hour visit. The document failed to evidence a RN signature or initial for the 5/10/13 to 7/8/13 certification period.</p> <p>3. During an interview on 8/5/13 at 2:15 PM, Employee B, Quality Assurance, indicated that the Home Health Aide Care Plan should have been signed or initialed and updated by the RN every 60 days.</p>			