

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157629	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2016
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NAME OF PROVIDER OR SUPPLIER EPIC HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
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G 0000 Bldg. 00	<p>This was a Federal home health validation survey. The survey was fully extended.</p> <p>Survey dates: 4/4/16 - 4/8/16</p> <p>Facility #: 12050</p> <p>Medicaid Vendor #: 200942280</p> <p>Medicare #: 157629</p> <p>Skilled unduplicated census in the past 12 months: 68 patients</p> <p>Epic Health Services, Inc. is precluded from providing its own home health training and competency evaluation for a period of two years beginning 4/8/16 - 4/8/18 due to being found out of compliance with the following Conditions: 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; and 42 CFR 484.48 Medical Records.</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 0109 Bldg. 00	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on record review and interview, the agency failed to ensure the patients were involved in planning for their discharge and care and had accurate knowledge of the care to be provided and right to be involved in planning changes in the care or treatment to be provided for 1 of 3 clinical records reviewed (#11) with patients listed as being "on hold."</p> <p>The findings include:</p> <p>1. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8 hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. Patient #11 had been placed "On Hold" on 4/4/16 without the patient's knowledge.</p>	G 0109	<p>All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy for Discharge. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/primary caregiver, and payer regarding patient being placed on hold or discharged will be documented in the clinical record.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 04/30/2016 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance</p>	04/30/2016	

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	<p>A. A clinical record document titled "Home Care Consent" and signed by the patient on 3/1/16 evidenced the patient received the Patient Rights at the start of care.</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>2. An agency document titled "Patient List" with a date of 4/4/16 evidenced patient #11 was on hold and had been admitted to the agency on 3/1/16.</p> <p>3. The document titled "Patient Rights" with no date stated, "As our patient, you and your family have the right to be treated with dignity, courtesy, and respect ... make informed decisions about your care, to receive information to help make decisions and to participate in developing, planning, and changing your care plan ... receive reasonable continuity</p>		may result disciplinary measures.	

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G 0121 Bldg. 00	<p>of care ... receive timely notice of impending discharge ... or to a different level of intensity of care."</p> <p>4. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted and order received."</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on home visit observation, interview, and record review, the agency failed to ensure staff had provided services in accordance with the agency's infection control policies and procedures in 5 of 5 home visits completed (Patient #3, #4, #6, #7, #9). The findings include:</p>	G 0121	All employees observed during the home visits have been re-educated on hand washing/hand hygiene and infection control practices. The nursing director sent out handwashing and nursing bag policies to all field nurses and home health aides via email and regular mail on 4/28/16. This information also included direction to notify the office if no	04/30/2016

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	<p>1. During a home visit observation on 4/5/16 at 8:20 AM, Employee C, Registered Nurse (RN) was observed to enter the home of patient #3. She was observed to place her nursing bag on the floor.</p> <p>2. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed at a home visit observation with patient #4. Her nursing bag was on the floor of the home.</p> <p>3. During a home visit observation on 4/5/16 at 12 noon, Employee B, Home Health Aide, was observed to wash her hands with patient #9's bar soap and use the patient's hand towel to dry her hands before caring for patient #9.</p> <p>4. During an interview on 4/5/16 at 5 PM, Employee A indicated infection control procedures were not followed at the visit with Employee B at the home of patient #9. Employee A indicated the agency did not have a policy on a clean barrier with nursing bag use at home visits.</p> <p>5. During a home visit observation on 4/6/16 at 8:10 AM, Employee F, RN was observed to wash her hands with soap and then the kitchen towel by the kitchen</p>		<p>handwashingsupplies are available in the home. Nursing Supervisors will supervise nursesand aides monthly during home visits to ensure hand washing and nursing bagprocedure is being followed. All nursesperforming infusion services will be re-educated to the Agency's InfusionTherapy policies and procedures by the Nursing Director. Supervisory visits will be done duringprovision of infusion therapy services to observe the nurses' technique anddocumented on the supervisory visit note. Any continued break in infection control practices by any field staffwill be documented as a disciplinary measure. ResponsibleParty: Nursing Director, Nursing Supervisors CompletionDate: 04/30/2016 Follow Up:The Nursing Director will review all supervisory visit notes for 4 weeks toensure compliance. Once 100% compliancemet, the Nursing Director will review a random sample of 10 supervisory visitsin a month to ensure that compliance is maintained.</p>		

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	<p>sink prior to caring for patient #6.</p> <p>During an interview on 4/6/16 at 4:35 PM, Employee A, administrator, indicated the handwashing at the visit with Employee F's visit did not follow agency procedure.</p> <p>6. During a home visit observation on 4/7/16 at 1:45 PM, Employee E, Licensed Practical Nurse, was observed to terminate the patient #7's TPN (Total Parenteral Nutrition) treatment while the patient was sitting at a high chair tray table. Employee E failed to clean the high chair table prior to completing the procedure.</p> <p>During an interview on 4/7/16 at 3:21 PM, Employee E agreed the agency procedure was not followed.</p> <p>7. An agency procedure titled "Infusion Therapy Self - Learning Module" with a date of 9/29/15 stated, "Hand hygiene is the single most effective way to prevent the spread of infection ... all medical procedures should be performed on a surface that is aseptic in the home setting ... maintaining an aseptic work area ... clean surface with bleach or antiseptic cleaner. Let surface dry ... cover area with available clean draping, cloth, diaper, towel, blue pad."</p>			

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G 0122 Bldg. 00	<p>8. The agency procedure titled "OSHA Training for Nursing New Hires" with no date stated, "Handwashing Technique ... Rinse hands thoroughly under running water ... apply nickel sized amount of hand rub / soap to the palm of hand ... vigorously rub hands together, scrubbing between fingers and up to wrists for 30 seconds ... rinse hands thoroughly under running water ... wipe hands using a clean towel.</p> <p>9. The agency document titled "Orientation Completion Acknowledgement - caregivers" with a revised date of 3/2012 evidenced Employees # C, D, E, and F received a copy of the nursing bag technique.</p> <p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p> <p>Based on record review and interview, it was determined the agency failed to ensure an administrator organized and directed the agency's ongoing functions for 1 of 1 agency (see G 133); the administrator failed to ensure the agency followed their policy for criminal history</p>	G 0122	G122 The Gtags cited in this condition,G133, G141, G143, and G144 are addressed under their individual tags G133 TheAdministrator reviewed and was educated on Administrator's job description andresponsibilities by Regional Operations Director. Administrator signed the job description on4/4/16. Going	04/30/2016

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	<p>checks for 2 of 16 personnel records reviewed (see G 141); the agency failed to evidence all personnel furnishing services documented the coordination of care while services were being provided for 3 of 13 records reviewed (see G 143, G 144); and the agency failed to ensure 60 day summaries sent to the physician included a description of the patient's current condition and the patient's progress for 3 of 6 records reviewed of services provided over 60 days (see G 145).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.14 Organization, Services, and Administration.</p>		<p>forward with any change in administrators meeting the state qualifications, the job description and duties will be clearly defined. Responsible Party: Regional Operations Director Completion Date: 04/08/2016 Follow Up: The Regional Operations Director will be responsible for orientation and training of any new Agency Administrators. G141 Background checks for all internal employees have been obtained from the corporate location as of 4/26/16. Going forward, the Administrator will ensure completion of criminal history checks on all applicants. The Administrator will review all background checks and have them secured in a locked cabinet in the office. All criminal background screenings will be given to the surveyor upon request by the Administrator per Indiana requirements. Responsible Party: Administrator Completion Date: 4/26/16. Follow Up: The Regional Operations Director will review all new internal employee files to ensure compliance with above. This will be an ongoing process. G143 All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy for Discharge, Physicians Orders, and Care Coordination. The Nursing Supervisors will review all patients needing to be placed</p>	

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			<p>on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/primary caregiver, and payer regarding patient being placed on hold or discharged will be documented in the clinical record. Case conferences will be held for all patients at time of recertification and as needed. The case conferences will be documented on the Agency's case conference form and kept in the patient file.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Case conferences will be tracked by the QA nurse for completion at recertification. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures. G144 All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy for</p>	

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			<p>Discharge, Physicians Orders, and Care Coordination. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/primary caregiver, and payer regarding patient being placed on hold or discharged will be documented in the clinical record. Case conferences will be held for all patients at time of recertification and as needed. The case conferences will be documented on the Agency's case conference form and kept in the patient file.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Case conferences will be tracked by the QA nurse for completion at recertification. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	

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G 0133 Bldg. 00	<p>484.14(c) ADMINISTRATOR</p> <p>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.</p> <p>Based on record review and interview, the agency failed to ensure a single administrator organized and directed the agency's ongoing functions for 1 of 1 agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. An organizational chart titled "Epic Health Services Valparaiso, IN" with no date evidenced Employee A was the administrator and Employee P was the executive director. 2. On 4/6/16 at 10:41 AM, Employee P indicated she was in charge of the financial part of the agency and oversaw the management and scheduling part of the agency. She would move to the management position officially in September 2016 when she had the one year of experience. She stated, "The lines are blurred between [Employee A] and me. We are working together." Employee P indicated paperwork was 	G 0133	<p>G133</p> <p>The Administrator reviewed and was educated on Administrator's job description and responsibilities by Regional Operations Director. Administrator signed the job description on 4/4/16. Going forward with any change in administrators meeting the state qualifications, the job description and duties will be clearly defined.</p> <p>Responsible Party: Regional Operations Director Completion Date: 04/08/2016 Follow Up: The Regional Operations Director will be responsible for orientation and training of any new Agency Administrators.</p>	04/08/2016	

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G 0141 Bldg. 00	<p>pending since she had just started today.</p> <p>3. On 4/8/16 at 11:16 AM, Employee A indicated she was in charge of the daily operations of the agency and worked with Employee P concerning the operation of the agency.</p> <p>4. The personnel file for Employee A showed a job description titled "Administrator" with a date of 4/4/16 and signed by Employee A.</p> <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 record review and interview, the administrator failed to ensure the agency followed their policy for criminal history checks for 2 of 16 personnel records reviewed (Employees #0 and P).</p> <p>The findings include:</p> <p>1. Employee file O, Licensed Practical</p>	G 0141	<p>G141 Backgroundchecks for all internal employees have been obtained from the corporatelocation as of 4/26/16. Going forward,the Administrator will ensure completion of criminal history checks on allapplicants. The Administrator willreview all back ground checks and have them secured in a locked cabinet in</p>	04/26/2016

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	<p>Nurse, with a date of hire 1/25/16 and no patient contact, failed to evidence a criminal history had been completed and contained in a personnel record.</p> <p>2. Employee File P, Executive Director with a date of hire of 9/21/15 and no patient contact, failed to evidence a criminal history had been completed and was contained in a personnel record.</p> <p>3. During an interview on 4/8/16 at 11:16 AM, Employee A, administrator, indicated the corporate office kept the criminal histories filed at the corporate office and not at the branch.</p> <p>4. The agency policy titled "Background Investigation" with a revised date of 10/2009 stated, "Criminal background screening for all applicants wishing to provide direct patient care."</p> <p>5. The agency policy titled "Licensure / Certification: Federal / State / Local Permits" with a date of 10/09 stated, "Each office will maintain compliance with all applicable local, state, and federal laws and regulations."</p>		<p>theoffice. All criminal backgroundscreenings will be given to the surveyor upon request by the Administrator perIndiana requirements. ResponsibleParty: Administrator CompletionDate: 4/26/16. FollowUp: The Regional Operations Directorwill review all new internal employee files to ensure compliance with above.This will be an ongoing process.</p>				

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G 0143 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on record review and interview, the agency failed to evidence all personnel furnishing services documented the coordination of care while services were being provided for 3 of 13 records reviewed (Patient #6, #8, #11).</p> <p>The findings include:</p> <p>Regarding clinical record #6</p> <ol style="list-style-type: none"> 1. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy." 2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated patient #6 had been receiving pureed foods including cereals. 3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 	G 0143	<p>G143 All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy for Discharge, Physicians Orders, and Care Coordination. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/primary caregiver, and payer regarding patient being placed on hold or discharged will be documented in the clinical record. Case conferences will be held for all patients at time of recertification and as needed. The case conferences will be documented on the Agency's case conference form and kept in the patient file. Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Case conferences will be tracked by the QA nurse for completion at</p>	04/30/2016

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	<p>3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as "restricted pureed."</p> <p>4. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>Concerning Clinical Record #8</p> <p>5. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator, indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>6. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient is on hold but there is no documentation of communications between agency staff, the physician, the</p>		<p>recertification Quarterly recordreviews of 10% or a minimum of 10 files will be done by the NursingDirector/Nursing Supervisors to ensure ongoing compliance with policy. Anybreak in policy found will result in re-education with any staff involved;continued non-compliance may result in disciplinary measures.</p>	

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	<p>patient / patient caregiver, or others regarding the hold status and the reasons the patient has been placed on hold.</p> <p>7. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This physician's order was dated 4/1/16 and signed by Employee N, Registered Nurse. This document did not include any information about why the patient had been placed on hold or resumption of care plans.</p> <p>Regarding Clinical Record #11</p> <p>8. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8 hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. The clinical record documentation failed to evidence the patient / informal caregiver had been informed about the patient's "On - Hold " Status. The physician had not informed about the resumption of care plans or the patient's need for the on hold services.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated,</p>			

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	<p>"Hold Home Health Services. This was signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>9. An agency document titled "Patient List" with a date of 4/4/16 evidenced patients #8 and #11 were on hold.</p> <p>10. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted and order received."</p> <p>11. The policy titled "Care Coordination" with a revised date of</p>			

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G 0144 Bldg. 00	<p>5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Fix this</p> <p>Based on record review and interview, the agency failed to evidence all personnel furnishing services documented the coordination of care while services were being provided for 3</p>	G 0144	<p>G144 All NursingSupervisors will be re-educated by the Nursing Director to the Agency's policyfor Discharge, Physicians Orders, and Care Coordination. The Nursing Supervisors will review allpatients needing to be placed on hold with the Nursing Director to ensure</p>	04/30/2016

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	<p>of 13 records (Patient #6 , #8, #11) reviewed.</p> <p>The findings include:</p> <p>Regarding clinical record #6</p> <p>1. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated patient #6 had been receiving pureed foods including cereals.</p> <p>3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as "restricted pureed."</p> <p>4. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed</p>		<p>theAgency's policy is being followed. Allcommunication with physician, family/primary caregiver, and payer regardingpatient being placed on hold or discharged will be documented in the clinicalrecord. Case conferences will be held for all patients at time ofrecertification and as needed. The caseconferences will be documented on the Agency's case conference form and kept inthe patient file.</p> <p>ResponsibleParty: Nursing Director, Nursing Supervisors</p> <p>CompletionDate: 4/30/16</p> <p>Follow Up:During the weekly clinical team meetings, all patients on hold will bediscussed to ensure on-going communication is being completed with physician,family/primary caregiver, and payer as applicable. Case conferences will betracked by the QA nurse for completion at recertification Quarterly recordreviews of 10% or a minimum of 10 files will be done by the Nursing Director/NursingSupervisors to ensure ongoing compliance with policy. Any break in policy foundwill result in re-education with any staff involved; continued non-compliancemay result in disciplinary measures.</p>		

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	<p>food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>Concerning Clinical Record #8</p> <p>5. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator, indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>6. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient is on hold but there is no documentation of communications between agency staff, the physician, the patient / patient caregiver, or others regarding the hold status and the reasons the patient has been placed on hold.</p> <p>7. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This physician's order was dated 4/1/16 and signed by Employee N, Registered Nurse. This document did not include any</p>			

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	<p>information about why the patient had been placed on hold or resumption of care plans.</p> <p>Regarding Clinical Record #11</p> <p>8. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8 hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. The clinical record documentation failed to evidence the patient / informal caregiver had been informed about the patient's "On - Hold " Status. The physician had not informed about the resumption of care plans or the patient's need for the on hold services.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated, "Hold Home Health Services. This was signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no</p>			
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	<p>coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>9. An agency document titled "Patient List" with a date of 4/4/16 evidenced patients #8 and #11 were on hold.</p> <p>10. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted and order received."</p> <p>11. The policy titled "Care Coordination" with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p>				

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G 0145 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on interview and record review, the home health agency failed to ensure 60 day summaries sent to the physician included a description of the patient's current condition and the patient's progress for 3 of 6 records reviewed of services provided over 60 days (Patient #1, #3, #7).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care 1/5/12, failed to evidence the 60 day summary had been updated with the patient's current condition and care provided for the certification periods of 12/9/15 - 2/6/16 and 2/7/16 - 4/6/16.</p> <p>The 60 day summary provided to the physician on the plan of care for the certification period of 2/7/16 - 4/16/16 stated, "60 day summary date of last physician visit: N/A [not applicable], date of hospitalization: 1/5/16, emergency</p>	G 0145	<p>G145 All NursingSupervisors were re-educated on the Agency's policy for Care Coordination.Information regarding the patient's progression to goals, status of problems,and a summary of care will be provided to the physician with eachrecertification. ResponsibleParty: Nursing Director CompletionDate: 4/30/16 Follow Up:The Nursing Director will review 10% or a minimum of 10 files quarterly toensure compliance with this requirement. Any continued break in compliance mayresult in disciplinary action. Thisrequirement will also be reviewed during the corporate compliance quarterlyaudit; Threshold for this is 100%.</p>	04/30/2016

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	<p>room visit: N / A, New medication orders: naproxen and pepcid, change in patient condition: none at this time, patient remains homebound due to: N / A." There was no report of progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p> <p>2. Clinical record #3, start of care 5/1/12 failed to evidence the 60 day summary had been updated with the patient's current condition and care provided between the certification periods of 2/26/15 - 2/22/16 and 2/23/16 - 5/16/16.</p> <p>A. The 60 day summary on the plan of care from 2/23/16 - 5/16/16 stated, "Date of last physician visit 3/11/2016, date of hospitalization: 1/4/16, emergency room visit 12/22/15, new medication order: none at this time, change in patient condition: none at this time, patient remains homebound at this time: N/A" There was no report of progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p> <p>3. Clinical record #7, start of care 5/21/15 failed to evidence the 60 day summary had been updated with the</p>			

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	<p>patient's current condition and care provided between the certification periods of 1/12/16 - 3/11/16 and 3/12/16 - 5/10/16</p> <p>A. The 60 day summary on the plan of care from 3/12/16 - 5/10/16 stated, "Date of last physician visit unknown, date of hospitalization: 2/29/16 -3/2/16 , emergency room visit 2/29/16, new medication order: yes, change in patient condition: no." There was no report of the medication changes or the progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p> <p>4. The agency policy titled "Care Coordination" with a revised date of 5/2014 stated, "The clinical manager or designee will send the physician a written summary, at least every 60 days ... the written summary to the physician includes a. a report of progress toward achievement of anticipated outcomes during the previous certification period for all services, b. The status of problems throughout the course of care c. A summary of care provided d. Status of progress towards goals during the previous period e. Patient and family response to the care and services provided.</p>			

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G 0156 Bldg. 00	<p>5. During an interview, on 4/7/16 at 3:50 PM, Employee A, administrator, indicated the 60 day summaries were not complete.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on record review, home visit observation, and interview, it was determined the agency failed to ensure patient needs were addressed and being met adequately in the patient's place of residence for 2 of 3 records reviewed of patients placed on hold (see G 157); failed to ensure care and services had been provided in accordance with physician orders in 5 of 13 records reviewed (see G 158); and failed to ensure the plan of care was accurate for 5 of 13 clinical records reviewed (see G 159).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G 0156	<p>G156 The Gtags cited in this condition,G157, G158, G159 are addressed under their individual tags</p> <p>G157 All NursingSupervisors will be re-educated by the Nursing Director to the Agency'sPhysician Orders policy. The Nursing Supervisors will review all patientsneeding to be placed on hold with the Nursing Director to ensure the Agency'spolicy is being followed. Allcommunication with physician, family/primary caregiver, and payer regardingpatient being placed on hold or discharged will be documented in the clinicalrecord. ResponsibleParty: Nursing Director CompletionDate: 04/30/2016 Follow Up:During the weekly clinical team meetings, all patients on hold will bediscussed to ensure on-going communication is being completed</p>	04/30/2016

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			<p>with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p> <p>G158 All field nurses were educated via email and regular mail to the Agency's Clinical Record policy. During home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician. Responsible Party: Nursing Director, Nursing Supervisor Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed</p>	

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			<p>with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p> <p>G159 All field nurses were re-educated via email and regular mail information regarding the requirement of following the POC and if any orders were questionable, then they are to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician.</p> <p>Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each</p>	

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G 0157 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.</p> <p>Based on record review and interview, the agency failed to ensure patient needs were addressed and being met adequately in the patient's place of residence for 2 of 3 records reviewed (Patient #8, #11) of patients placed on hold.</p> <p>Regarding clinical record #8</p> <p>1. Clinical record #8 was placed on hold on 4/1/16. The order for this "On Hold" was not completed per policy. There were no resumption of care plans on the "On Hold" order sent to the physician per policy.</p>	G 0157	<p>workingnurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%.</p> <p>G157 All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's Physician Orders policy. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/primary caregiver, and payer regarding patient being placed on hold or discharged will be documented in the clinical record. Responsible Party: Nursing Director Completion Date: 04/30/2016 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed</p>	04/30/2016

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	<p>2. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator, indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>3. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient was on hold but there was no documentation of communications between agency staff, the physician, the patient / patient caregiver, or others regarding the hold status and the reasons the patient had been placed on hold.</p> <p>4. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This was dated 4/1/16 and signed by Employee N, Registered Nurse.</p> <p>Regarding clinical record #11</p> <p>5. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. The care for this patient started on 3/1/16 and not 2/16/16. An initial assessment visit on 3/1/16 and home health aide visits occurred on 3/1/16, 3/2/16, 3/3/16,</p>		<p>with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	

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	<p>3/4/16, 3/11/16, 3/14/16, 3/15/16, 3/16/16, 3/17/16, 3/21/16, 3/22/16, 3/23/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, and 3/30/16. This patient was placed on hold on 4/1/16. The reason for the on hold status was not on the order sent to the physician.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated, "Hold Home Health Services. This was signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the certification period was in error and that the patient had been placed on hold.</p> <p>6. The agency policy titled "Physician's Order" with a revised date of 5/2014 stated, "Physician's orders must be obtained for services ... by all health care personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs. It includes all pertinent diagnosis, surgical history ... types of services and equipment required. hours or frequency</p>			

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G 0158 Bldg. 00	<p>of visits / shifts ... the company plan of treatment form will be used ... the plan of treatment will be reviewed and revised as needed and at least every 60 days and as necessary based on state requirement ... when a patient is placed on hold, there must be an order to the physician declaring that services are being held, why, and plan for resumption. The POC must continue to be submitted to the physician for signature, noting on there that the physician is on hold and the reason."</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 record review and interview, the agency failed to ensure care and services had been provided in accordance with the physician ordered plan of care in 5 of 13 records reviewed (Patient #1, #3, #4, #6, #12).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care (SOC)</p>	G 0158	G158 All fieldnurses were educated via email and regular mail to the Agency's Clinical Recordpolicy. During home visits, the staffnurse's documentation will be reviewed to ensure compliance with policy.Nursing Supervisors were re-educated by the Nursing Director to the Agencypolicy for Physician's Orders and the need to review all orders prior tosending to MD for	04/30/2016

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	<p>1/5/12 and diagnosis of muscular dystrophy, included a plan of care for the certification period of 2/7/16 - 4/6/16 and included orders for the skilled nurse to visit 11 - 13 hours a day 5 - 7 days a week. The orders evidenced the skilled nurse was to complete cough assist treatment daily and CPT (chest percussion therapy) vest treatment daily prior to cough assist.</p> <p>A. A skilled nursing flowsheet dated 3/9/16 and signed by Employee R, Licensed Practical Nurse (LPN) evidenced the CPT Vest treatment and cough assist were not completed as ordered.</p> <p>B. A skilled nursing flowsheet dated 3/12/16 and signed by Employee T, Registered Nurse (RN), evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>C. A skilled nursing flowsheet dated 3/13/16 and signed by Employee S, LPN, evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>D. A skilled nursing flowsheet dated 3/16/16 and signed by Employee R, LPN, evidenced the CPT vest treatment was not completed as ordered.</p>		<p>accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisor Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	

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	<p>E. On 4/6/16 at 1:40 PM, Employee U, RN, indicated the above visits did not follow the plan of care.</p> <p>2. Clinical record #3, start of care 5/1/12 and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care evidenced the patient was to be weighed weekly and results called to a home care pharmacy company. No weights were documented from 2/23/16 - 3/21/16 as evidenced below:</p> <p>A. A skilled nursing flowsheet with a date of 2/23/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>B. A skilled nursing flowsheet with a date of 2/25/16 and sinuate of Employee C, RN evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>C. A skilled nursing flowsheet with a date of 3/1/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p>			
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	<p>D. A skilled nursing flowsheet with a date of 3/3/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>E. A skilled nursing flowsheet with a date of 3/8/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>F. A skilled nursing flowsheet with a date of 3/15/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>G. A skilled nursing flowsheet with a date of 3/17/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>H. A skilled nursing flowsheet with a date of 3/22/16 and signature of Employee C, RN, evidenced the patient was weighed and the results were called to the pharmacy.</p> <p>I. During an interview on 4/7/16 at 4:20 PM, Employee A, administrator,</p>			

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	<p>indicated there was a lack of documentation with the weekly weights to be completed for this patient.</p> <p>3. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for a oxygen saturation rate to be taken at each visit. Oxygen saturation rates were not documented for visits on 3/24/16, 3/25/16, 3/29/16, and 4/1/16 by the skilled nurses.</p> <p>On 4/7/16 at 4:10 PM, Employee A, administrator, indicated the plan of care had not been followed at the above visits.</p> <p>4. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior [hypoallergenic baby formula] and not Elecare as ordered</p>			

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	<p>on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecure Jr.</p> <p>A. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the care did not follow the plan of care for this record.</p> <p>5. Clinical record #12, start of care 2/12/16 and diagnosis of Type 2 Diabetes, included a plan of care for the certification period of 2/8/16 - 4/7/16. The verbal start of care date was 1/26/16 and the physician signed on the same date. There was no frequency or duration on this plan of care for often the home health aide was to visit. An initial assessment was completed on 2/1/16. Home health aide visits occurred from 2/13/16 - 3/26/16 except on 2/14/16, 2/21/16, 2/28/16, 3/6/16, 3/13/16, and 3/20/16. Tasks completed included a partial bed bath, mouth care set -up, assist with dressing, assisting to the toilet and changing briefs.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the plan of care was not accurate.</p> <p>6. The agency policy titled "Physician's Orders" with a revised date of 4/2014 stated, "Physician's orders must be obtained for services ... by all healthcare personnel as required by state regulation</p>			

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G 0159 Bldg. 00	<p>... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the plan of care was accurate and updated for 5 of 13 clinical records reviewed (Patient #3, #4, #6, #11, #12).</p> <p>The findings include:</p> <p>1. Clinical record #3, start of care 5/1/12</p>	G 0159	<p>G159 All fieldnurses were re-educated via email and regular mail information regarding therequirement of following the POC and if any orders were questionable, then theyare to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing Director to the Agencypolicy for Physician's</p>	04/30/2016

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	<p>and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care was for 90 day period instead of a 60 day period.</p> <p>During an interview on 4/6/16 at 3 PM, Employee A, the administrator, indicated the certification period was for 90 days instead of 60 days.</p> <p>2. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 failed to evidence an individualized patient plan of care as evidenced by the lack of updated orders and vital sign parameters. The plan of care / physician orders failed to include orders to feed the patient via an infant bottle Simalac. This was evidenced by the following:</p> <p>A. A clinical record document titled "Home Health Certification and Plan of Care" for the certification period of 3/12/16 - 5/10/16 stated, "Vital Sign Parameters [Patient Specific] ... notify MD [medical doctor] and / or RN supervisor for any VS [vital signs] outside listed parameters greater than 30 - 60 minutes greater than 30 - 60 minutes post intervention that are not resolved ... Skilled nurse to maintain NG</p>		<p>Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician.</p> <p>Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each working nurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%.</p>		

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	<p>[nasogastric] tube placement via aspiration and auscultation prior to administration of feeds and medications ... SN to bathe / shower patient every shift and prn."</p> <p>B. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed to feed 1 ounce of formula which included the patient's liquid medications: Phenobarbital and a multi vitamin with iron.</p> <p>C. On 4/7/16 at 4:30 PM, Employee A, administrator, indicated the plan of care had not been individualized for patient #4's medical care nor updated with the patient's current nutritional orders. Employee A indicated the computer program had an automatic click that probably produced the bathe / shower order and indicated this patient would not be appropriate to shower.</p> <p>3. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a</p>			

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	<p>week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior [hypoallergenic nutritional baby formula] and not Elecare as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week. The record of patient #6 failed to inicate the physician orders was updated to reflect what the caregiver idnicated had changed nor was there physician clarification sought to ensure the medical plan of care was accurate.</p> <p>B. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the plan of care had not been updated.</p> <p>4. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. The care for this patient started on 3/1/16</p>			

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	<p>and not 2/16/16. An initial assessment visit on 3/1/16 and home health aide visits occurred on 3/1/16, 3/2/16, 3/3/16, 3/4/16, 3/11/16, 3/14/16, 3/15/16, 3/16/16, 3/17/16, 3/21/16, 3/22/16, 3/23/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, and 3/30/16.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the certification period was in error.</p> <p>5. Clinical record #12, start of care 2/12/16 and diagnosis of Type 2 Diabetes, included a plan of care for the certification period of 2/8/16 - 4/7/16. The verbal start of care date was 1/26/16 and the physician signed on the same date. There was no frequency or duration on this plan of care for often the home health aide was to visit. An initial assessment was completed on 2/1/16. Home health aide visits occurred from 2/13/16 - 3/26/16 except on 2/14/16, 2/21/16, 2/28/16, 3/6/16, 3/13/16, and 3/20/16. Tasks completed included a partial bed bath, mouth care set -up, assist with dressing, assisting to the toilet and changing briefs.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the plan of care</p>			

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G 0168 Bldg. 00	<p>was not accurate.</p> <p>6. The agency policy titled "Physician's Order" with a revised date of 5/2014 stated, "Physician's orders must be obtained for services ... by all health care personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs. It includes all pertinent diagnosis, surgical history ... types of services and equipment required. hours or frequency of visits / shifts ... the company plan of treatment form will be used ... the plan of treatment will be reviewed and revised as needed and at least every 60 days and as necessary based on state requirement."</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the skilled nurse provided care in accordance with physician orders in 4 of 7 records reviewed with skilled nursing (see G 170), the Registered Nurse accurately and completely evaluated the patient for the start of care assessment in</p>	G 0168	G168 The Gtags cited in this condition,G170, G171, G176, G182 are addressed under their individual tags. G170 All fieldnurses were re-educated via email and regular mail information regarding therequirement of following the POC and if any orders were questionable, then theyare to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing	04/30/2016

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	<p>2 of 13 records reviewed (see G 171), failed to evidence the registered nurse documented the coordination of care while services were being provided for 1 of 7 records reviewed of patients with skilled nursing services (See G 176), and the licensed practical nurse failed to establish an aseptic field while completing a treatment for 1 of 1 home visit observations with a licensed practical nurse (See G 182).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.30 Skilled Nursing Services.</p>		<p>Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician. Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each working nurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. G171 All nursing supervisor were re-educated by the Nursing Supervisor on the requirement of completing and documenting a comprehensive assessment during all patient visits. The Nursing Supervisors will be educated to review all documentation for accuracy and completion prior to entering it into the patient's record. ...</p>	

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			<p>Responsible Party:Nursing Director CompletionDate: 4/30/16 Follow Up:The Nursing Director will review 10% or a minimum of 10 files quarterly toensure compliance with this requirement. Any continued break in compliance mayresult in disciplinary action. This requirementwill also be reviewed during the corporate compliance quarterly audit;Threshold for this is 100%. G176 All NursingSupervisors were re-educated on the Agency's policy for Care Coordination by the NursingDirector. Case conferences will be heldfor all patients at time of recertification and as needed. The case conferences will be documented onthe Agency's case conference form and kept in the patient file. CompletionDate: 4/30/16 ResponsibleParty: Nursing Director FollowUp: Case conferences will be tracked bythe QA nurse for completion at recertification. Quarterly record reviews of 10% or a minimum of 10 files will be done bythe Nursing Director/Nursing Supervisors to ensure ongoing compliance withpolicy. Any break in policy found will result in re-education with any staffinvolved; continued non-compliance may result in disciplinary measures G182 All nursesperforming infusion services will be re-educated by the Nursing Supervisorand/or</p>	

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G 0170 Bldg. 00	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the agency failed to ensure the skilled nurse provided care in accordance with physician orders in 4 of 7 records reviewed with skilled nursing (Patient #1, #3, #4, #6).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care (SOC)</p>	G 0170	<p>Nursing Director to the Agency's Infusion Therapy policies and procedures. Supervisory visits will be done during provision of infusion therapy services to observe the nurses' technique and documented on the supervisory visit note. Any continued break in infection control practices by any field staff will be documented as a disciplinary measure. Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: Nursing Director will review all supervisory visits done to observe provision of infusion therapy to ensure documentation of compliance with policy/procedures for 1 month; ongoing the Nursing Director will randomly review supervisory visits done for patients receiving infusion services to ensure ongoing compliance.</p> <p>G170 All field nurses were re-educated via email and regular mail information regarding the requirement of following the POC and if any orders were questionable, then they are to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all</p>	04/30/2016

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	<p>1/5/12 and diagnosis of muscular dystrophy, included a plan of care for the certification period of 2/7/16 - 4/6/16 and included orders for the skilled nurse to visit 11 - 13 hours a day 5 - 7 days a week. The orders evidenced the skilled nurse was to complete cough assist treatment daily and CPT (chest percussion therapy) vest treatment daily prior to cough assist.</p> <p>A. A skilled nursing flowsheet dated 3/9/16 and signed by Employee R, Licensed Practical Nurse (LPN) evidenced the CPT Vest treatment and cough assist were not completed as ordered.</p> <p>B. A skilled nursing flowsheet dated 3/12/16 and signed by Employee T, Registered Nurse (RN), evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>C. A skilled nursing flowsheet dated 3/13/16 and signed by Employee S, LPN, evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>D. A skilled nursing flowsheet dated 3/16/16 and signed by Employee R, LPN, evidenced the CPT vest treatment was not completed as ordered.</p>		<p>orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician.</p> <p>Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each working nurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%.</p>		

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	<p>E. On 4/6/16 at 1:40 PM, Employee U, RN, indicated the above visits did not follow the plan of care.</p> <p>2. Clinical record #3, start of care 5/1/12 and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care evidenced the patient was to be weighed weekly and results called to a home care pharmacy company. No weights were documented from 2/23/16 - 3/21/16 as evidenced below:</p> <p>A. A skilled nursing flowsheet with a date of 2/23/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>B. A skilled nursing flowsheet with a date of 2/25/16 and sinuate of Employee C, RN evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>C. A skilled nursing flowsheet with a date of 3/1/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p>			

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	<p>D. A skilled nursing flowsheet with a date of 3/3/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>E. A skilled nursing flowsheet with a date of 3/8/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>F. A skilled nursing flowsheet with a date of 3/15/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>G. A skilled nursing flowsheet with a date of 3/17/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>H. A skilled nursing flowsheet with a date of 3/22/16 and signature of Employee C, RN, evidenced the patient was weighed and the results were called to the pharmacy.</p> <p>I. During an interview on 4/7/16 at 4:20 PM, Employee A, administrator,</p>			

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	<p>indicated there was a lack of documentation with the weekly weights to be completed for this patient.</p> <p>3. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for a oxygen saturation rate to be taken at each visit. Oxygen saturation rates were not documented for visits on 3/24/16, 3/25/16, 3/29/16, and 4/1/16 by the skilled nurses.</p> <p>On 4/7/16 at 4:10 PM, Employee A, administrator, indicated the plan of care had not been followed at the above visits.</p> <p>4. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior [hypoallergenic nutritional baby formula] and not Elecare</p>			

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G 0171 Bldg. 00	<p>as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the care did not follow the plan of care for this record.</p> <p>5. The agency policy titled "Physician's Orders" with a revised date of 4/2014 stated, "Physician's orders must be obtained for services ... by all healthcare personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on record review and interview, the agency failed to ensure the Registered</p>	G 0171	G171 All nursingsupervisor were re-educated by the Nursing Supervisor on the requirement	04/30/2016

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G 0176	<p>Nurse (RN) accurately and completely evaluated the patient for the start of care assessment in 2 of 13 records reviewed (Patient #9, #11).</p> <p>The findings include:</p> <p>1. Clinical record #9, start of care 1/27/16 and diagnosis of Type 2 Diabetes, evidenced an initial assessment completed by the RN on 1/27/16. This assessment failed to evidence a blood pressure had been completed at this visit.</p> <p>During an interview on 4/8/16 at 3:10 PM, Employee A, administrator, indicated the assessment was not complete.</p> <p>2. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, evidenced an initial assessment completed by the RN on 3/1/16. This assessment failed to evidence the height, weight, and blood pressure had been completed at this visit.</p> <p>On 4/8/16 at 10:38 AM, Employee A, administrator, indicated the initial assessment was not complete.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p>		<p>ofcompleting and documenting a comprehensive assessment during all patientvisits. The Nursing Supervisors will beeducated to review all documentation for accuracy and completion prior toentering it into the patient's record. . .</p> <p>Responsible Party:Nursing Director CompletionDate: 4/30/16 Follow Up:The Nursing Director will review 10% or a minimum of 10 files quarterly toensure compliance with this requirement. Any continued break in compliance mayresult in disciplinary action. This requirementwill also be reviewed during the corporate compliance quarterly audit;Threshold for this is 100%.</p>				

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Bldg. 00	<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 record review and interview, the agency failed to evidence the registered nurse documented the coordination of care while services were being provided for 1 of 7 records reviewed of patients with skilled nursing services (Patient #6).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy." 2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient #6 had been receiving pureed foods including cereals. 3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as "restricted pureed." 4. During an interview on 4/6/16 at 	G 0176	<p>G176</p> <p>All NursingSupervisors were re-educated on the Agency's policy for Care Coordination by the NursingDirector. Case conferences will be heldfor all patients at time of recertification and as needed. The case conferences will be documented onthe Agency's case conference form and kept in the patient file.</p> <p>CompletionDate: 4/30/16</p> <p>ResponsibleParty: Nursing Director</p> <p>FollowUp: Case conferences will be tracked bythe QA nurse for completion at recertification. Quarterly record reviews of 10% or a minimum of 10 files will be done bythe Nursing Director/Nursing Supervisors to ensure ongoing compliance withpolicy. Any break in policy found will result in re-education with any staffinvolved; continued non-compliance may result in disciplinary measures.</p>	04/30/2016

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G 0182 Bldg. 00	<p>11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>5. The policy titled "Care Coordination" with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares</p>			

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	<p>equipment and materials for treatments, observing aseptic technique as required.</p> <p>Based on record review, home visit observation, and interview, the licensed practical nurse failed to establish an aseptic field while completing a treatment for 1 of 1 home visit observations with a licensed practical nurse (Employee E with patient #7).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During a home visit observation on 4/7/16 at 1:45 PM, Employee E, Licensed Practical Nurse, was observed to terminate the patient #7's TPN (Total Parenteral Nutrition) treatment while the patient was sitting at a high chair tray table. Employee E failed to clean the high chair table prior to completing the procedure. During an interview on 4/7/16 at 3:21 PM, Employee E agreed the agency procedure was not followed. 2. An agency procedure titled "Infusion Therapy Self - Learning Module" with a date of 9/29/15 stated, "Hand hygiene is the single most effective way to prevent the spread of infection ... all medical procedures should be performed on a surface that is aseptic in the home setting ... maintaining an aseptic work area ... 	G 0182	<p>G182</p> <p>All nurses performing infusion services will be re-educated by the Nursing Supervisor and/or Nursing Director to the Agency's Infusion Therapy policies and procedures. Supervisory visits will be done during provision of infusion therapy services to observe the nurses' technique and documented on the supervisory visit note. Any continued break in infection control practices by any field staff will be documented as a disciplinary measure.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: Nursing Director will review all supervisory visits done to observe provision of infusion therapy to ensure documentation of compliance with policy/procedures for 1 month; ongoing the Nursing Director will randomly review supervisory visits done for patients receiving infusion services to ensure ongoing compliance.</p>	04/30/2016

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G 0212 Bldg. 00	<p>clean surface with bleach or antiseptic cleaner. Let surface dry ... cover area with available clean draping, cloth, diaper, towel, blue pad."</p> <p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on record review and interview, the agency failed to evidence 4 of 5 home health aides (#G, #H, #J, #K) were evaluated for competency in each bathing skill performed for patients with that skill assigned.</p> <p>The findings include:</p> <p>1. The file for employee G, date of hire 12/10/15 and first patient contact date 1/11/16, contained Employee G's skills competency sheet. The Home Health Aide Competency Evaluation dated 12/10/15 and 1/11/16 failed to evidence that Employee G was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing,</p>	G 0212	<p>G212 All NursingSupervisors will be re-educated by the Nursing Director to the Agency's policyHome Health Aide Competency Evaluation and Training All Home Health Aide files will be reviewedto ensure competency documented for all skills. Any found deficient will be brought in to the Agency for retraining andobservation of skills competency. Thiswill be documented on the Home Health Aide competency form. ResponsibleParty: Nursing Director, Nursing Supervisors CompletionDate: 5/1/16 Follow Up:The Nursing Director will review the files for documentation of skillscompetency of any new home health aides hired until 6/30/16. After this a random review will be done toensure ongoing</p>	05/01/2016

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	<p>nail / skin care, oral hygiene. This document was signed by Employee G on 12/10/15, Employee N, Registered Nurse on 12/10/15, and Employee L, RN on 1/11/16. The only task on this list observed and evaluated as competent was documents and reports observation of client status and care rendered.</p> <p>Clinical record #9 evidenced Employee G had given patient #9 a shower on 2/23/16 and 2/26/16. Employee G had not been deemed competent in showering a patient.</p> <p>2. The file for employee H, date of hire 1/19/16 and first patient contact date 2/19/16, contained Employee H's skills competency sheet. The Home Health Aide Competency Evaluation dated 1/19/16 and 2/19/16 failed to evidence that Employee H was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care, and oral hygiene. This document was signed by Employee H on 1/19/16 and Employee L on 1/19/16 and 2/19/16. The only tasks that were observed and showed that the employee was competent were personal hygiene related to toileting and elimination, safe transfers and ambulation techniques, and communication skills.</p>		<p>compliance. This requirement is also reviewed during the corporate compliance quarterly audit with a threshold of 100%.</p>	

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	<p>Clinical record #10 evidenced that on 2/21 - 2/26/16 Employee H have gave patient #10 bed baths and sponge baths to this patient. Employee H had not been deemed competent in these tasks.</p> <p>3. The file for Employee J, date of hire 11/19/15 and first patient contact date 12/2/15, contained Employee J's skills competency sheet. The Home Health Aide Competency evaluation dated 11/19/15 and signed by Employee J and Employee A, administrator on 11/19/15 and Employee L on 11/27/15 failed to evidence that Employee J was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care and oral care.</p> <p>Clinical record #13 evidenced Employee J assisted patient #13 with a shower on 12/11/15.</p> <p>4. The file for employee K, date of hire 8/20/15 and first patient contact date 8/21/15, contained Employee H's skills competency sheet. The Home Health Aide Competency Evaluation dated 8/21/15 failed to evidence that Employee H was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care, and oral hygiene. This document was</p>			

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	<p>signed by Employee K on 1/19/16 and Employee L on 8/21/15.</p> <p>Clinical record #12 evidenced Employee K gave partial bed baths to patient #12 on 2/22/16, 2/23/16, and 2/25/16.</p> <p>5. The agency policy titled "Home Health Aide Competency Evaluation and Training" with a revised date of 10/2009 stated, "Home Health aides ... must show acceptable proof of having passed any training and / or testing required by federal / state regulation or pass the Company training and / or testing program that meets the requirements prior to assignment ... if a home health aide does not present appropriate documentation of the above requirements they must complete the approved company training and competency program."</p> <p>6. During an interview on 4/8/16 at 9:35 AM, the administrator indicated the home health aide competencies did not evidence the home health aides were competent in the tasks they were completing.</p>				

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G 0215 Bldg. 00	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAINING</p> <p>The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on interview and record review, the agency failed to ensure 2 of 3 home health aide files (Y and Z) reviewed of aides hired in 2015 had completed the required number of inservices for 2015.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The personnel file for Employee Y, date of hire 8/26/15, failed to evidence she attended any inservices in 2015. 2. The personnel file for Employee Z, date of hire 10/29/15 failed to evidence she attended any inservices in 2015. 3. During an interview, on 4/8/16 at 3 PM, Employee A, administrator, indicated Employee Y and Z did not attend enough inservices in 2015. 4. The agency policy titled "Licensure / Certification: Federal / State / Local Permits" with a date of 10/09 stated, "Each office will maintain compliance with all applicable local, state, and federal laws and regulations." 	G 0215	<p>G215</p> <p>Nursing Supervisors and any internal staff that monitor the employee's compliance with the in-service regulation will be re-educated by the Nursing Director on the requirement for Home Health Aides to receive 12hrs of in-service education within a calendar year. All Home Health Aide employee files will be reviewed to ensure compliance with this regulation for the calendar year 2015. Any aides that have not completed the required inservices will be notified and brought into the Agency for completion. A sign-in sheet documenting attendance at any on-site inservices will be maintained for all inservices presented. Any inservices done by reading and testing will be documented on an answer sheet with the name of the inservices, date completed, name of employee, and number of credit hours given. All documentation of inservices will be placed in the employee file. Responsible Party: Nursing Director, Administrator Completion date: 5/15/16 Follow Up: The Administrator/designee will do a</p>	05/15/2016

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G 0235 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>Based on record review and interview, it was determined the agency failed to maintain clinical records in accordance with its own policy in 3 of 13 records reviewed creating the potential to affect all of the agency's patients (See G 236).</p> <p>The cumulative effect of this problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Medical Records.</p>	G 0235	<p>quarterly audit of 10% of all home healthaide files to ensure ongoing compliance. This requirement will also be reviewed during the corporate compliancequarterly audit for a threshold of 100%</p> <p>G235 The Gtags cited in this condition,G236 are addressed under their individual tags.</p> <p>G236 All fieldnurses were educated via email and regular mail to the Agency's Clinical Recordpolicy. During home visits, the staffnurse's documentation will be reviewed to ensure compliance with policy.Nursing Supervisors were re-educated by the Nursing Director to the Agencypolicy for Physician's Orders and the need to review all orders prior tosending to MD for accuracy and completeness. During all home visits, the POCwill be reviewed with the staff nurse/aide to ensure that all orders are beingcarried out. Any issues identified that need clarification or change will becommunicated to the physician. Responsible Party: Nursing Director, NursingSupervisor CompletionDate: 4/30/16 Follow Up:During the weekly clinical team meetings, all patients on hold will bediscussed to ensure on-going</p>	04/30/2016

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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 record review and interview, the agency failed to maintain clinical records in accordance with its own policy in 3 of 13 records reviewed (Patient #2, #4, #6)</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care (SOC) 11/2/12 and diagnosis of other congenital malformation of the spine not associated with scoliosis, included a skilled visit</p>	G 0236	<p>communication is being completed with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p> <p>G236 All field nurses were educated via email and regular mail to the Agency's Clinical Record policy. During home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During</p>	04/30/2016

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	<p>note on 3/15/16 completed by Employee V, licensed practical nurse, which evidenced the patient received water and Kid Essent in the amount of 105 milliliters at 5 PM. This amount was written over the numbers "100" with both entries.</p> <p>During a interview on 4/7/16 at 1 PM, Employee M, Registered Nurse, indicated the clinical documentation was not corrected per agency policy.</p> <p>2. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 failed to evidence an individualized patient plan of care as evidenced by the lack of updated orders and vital sign parameters. The plan of care / physician orders failed to include orders to feed the patient via a infant bottle Simalac. This was evidenced by the following:</p> <p>A. A clinical record document titled "Home Health Certification and Plan of Care" for the certification period of 3/12/16 - 5/10/16 stated, "Vital Sign Parameters [Patient Specific] ... notify MD [medical doctor] and / or RN supervisor for any VS [vital signs] outside listed parameters greater than 30 - 60 minutes greater than 30 - 60 minutes</p>		<p>all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician. Responsible Party: Nursing Director, Nursing Supervisor Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/primary caregiver, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>				

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	<p>post intervention that are not resolved ... Skilled nurse to maintain NG [nasogastric] tube placement via aspiration and auscultation prior to administration of feeds and medications ... SN to bathe / shower patient every shift and prn."</p> <p>B. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed to feed 1 ounce of formula which included the patient's liquid medications: Phenobarbital and a multi vitamin with iron.</p> <p>C. On 4/7/16 at 4:30 PM, Employee A, administrator, indicated the plan of care had not been individualized for patient #4's medical care nor updated with the patient's current nutritional orders. Employee A indicated the computer program had an automatic click that probably produced the bathe / shower order and indicated this patient would not be appropriate to shower.</p> <p>3. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 -</p>			

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	<p>5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior and not Elecare as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr. On 3/4/16, 3/16/16, 3/17/16, 3/18/16, 3/22/16, 3/23/16, 3/24/16, 3/30/16, and 3/31/16, the skilled nurse documented the patient received Elecare. The physician had given an order for pureed diet to be given to the patient if the speech therapist cleared the patient. There was no documentation that the speech therapist had cleared the patient but the patient had received the upgraded diet at skilled nurse visits.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. Clinical record #6 included a physician's order dated 3/3/16 and signed</p>			

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	<p>by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>1. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as restricted pureed.</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the caregiver of patient #6 had been receiving pureed foods including cereals.</p> <p>C. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the documentation was not accurate for this record.</p> <p>D. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>4. The policy titled "Care Coordination"</p>			

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G 0321 Bldg. 00	<p>with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>5. The policy titled "Clinical Records" with a date of 5/2014 stated, "Original, complete, accurate, and confidential clinical records will be maintained on all patients ... the clinical record in the branch is a legal document. All information must be entered accurately, legibly, and signed with the clinician's legal name and title. Corrections and additions to clinical record documentation will be entered only in a legally acceptable manner."</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.</p> <p>Based on record review and interview, the agency failed to ensure OASIS data</p>	G 0321	G321 All NursingSupervisors and QA Nurse will be re-educated by the Nursing	04/30/2016

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	<p>had been transmitted within 30 days of completion in 2 of 2 records reviewed of adult patients who received skilled services and had required comprehensive assessments. (#1 and #2).</p> <p>The findings include:</p> <p>1. Clinical record #1 included a recertification assessment completed on 2/1/16 but not transmitted until 3/24/16.</p> <p>A. ISDH documents evidenced a recertification assessment completed on 2/1/16 but not transmitted until 3/24/16.</p> <p>B. During an interview on 4/4/16 at 2:45 PM, the Employee A, administrator, indicated the oasis submission was not sent on time.</p> <p>2. Clinical record #2 included a recertification assessment completed on 9/22/15 but not transmitted until 11/4/5.</p> <p>A. ISDH Documents evidenced a recertification assessment completed on 9/22/15 but not transmitted until 11/4/15.</p> <p>B. During an interview on 4/7/16 at 4:08 PM, Employee A indicated the assessment was sent late.</p> <p>C. The agency document titled</p>		<p>Director to therequirement of transmitting OASIS data within 30 days of assessment. Nursing Supervisors will be trained to notifythe QA Nurse that the OASIS assessment is complete; the QA Nurse will thentransmit and obtain a final validation report to ensure acceptance of data.</p> <p>ResponsibleParty: Nursing Director, QA Nurse</p> <p>Completion Date: 4/30/16</p> <p>100% finalvalidation reports will be reviewed by the Nursing Director for 60days; then arandom sample of a minimum of 5 reports will be reviewed ongoing. This requirement is also reviewed during thequarterly corporate compliance audit. The sample size for that audit is 10% of census or a minimum of 10 files and 100% threshold. Any reports indicating rejection will bereviewed by the Nursing Director and theissues addressed as necessary.</p>	

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G 0331 Bldg. 00	<p>"CMS Submission Report" with a print date of 11/6/16 evidenced the agency sent a recertification assessment completed on 9/22/15 on 11/4/15.</p> <p>3. The agency policy titled "OASIS - C ASSESSMENT" with a date of 5/2015 stated, "The OASIS - C DATA items from the assessment of adult patients ... will be encoded and transmitted within 30 calendar days of the completion of the OASIS - C assessment."</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) accurately and completely evaluated the patient for the start of care assessment in 2 of 13 records reviewed (Patient #9, #11). The findings include: 1. Clinical record #9, start of care</p>	G 0331	G331 All nursingsupervisor were re-educated by the Nursing Supervisor on the requirement ofcompleting and documenting a comprehensive assessment during initial patientvisits. The Nursing Supervisors will beeducated to review all documentation for accuracy and completion prior toentering it into the patient's	04/30/2016

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G 0332 Bldg. 00	<p>1/27/16 and diagnosis of Type 2 Diabetes, evidenced an initial assessment completed by the RN on 1/27/16. This assessment failed to evidence a blood pressure had been completed at this visit.</p> <p>During an interview on 4/8/16 at 3:10 PM, Employee A, administrator, indicated the assessment was not complete.</p> <p>2. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, evidenced an initial assessment completed by the RN on 3/1/16. This assessment failed to evidence the height, weight, and blood pressure had been completed at this visit.</p> <p>On 4/8/16 at 10:38 AM, Employee A, administrator, indicated the initial assessment was not complete.</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 record review and interview,</p>	G 0332	<p>record. ..</p> <p>ResponsibleParty: Nursing Director CompletionDate: 4/30/16 Follow Up:The Nursing Director will review 10% or a minimum of 10 files quarterly toensure compliance with this requirement. Any continued break in compliance mayresult in disciplinary action. Thisrequirement will also be reviewed during the corporate compliance quarterlyaudit; Threshold for this is 100%.</p>	04/30/2016	

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N 0000 Bldg. 00	<p>the agency failed to ensure the Registered Nurse made an initial assessment within 48 hours of referral in 1 of 13 records reviewed (Patient #10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #10, Start of care 2/19/16, evidenced a referral document with a date of 2/9/16 and the initial assessment was completed on 2/19/16. 2. During an interview on 4/6/16 at 2 PM, Employee L, Registered Nurse, indicated the customer service intake coordinator, Employee X was late with his assessment and that delayed the start of care assessment. <p>This was a state home health relicensure survey.</p>	N 0000	<p>The Nursing Supervisors will bere-educated by the Nursing Director to the requirement of performing an initialassessment within 48hrs of referral. Ifthere are issues precluding this assessment being done within the required48hrs, they will be documented on the intake form and placed in the patientsclinical record. The physician,family/primary caregiver, and payer will be notified of the delay inassessment; this communication will be documented in the patient's clinicalrecord. Responsible party: Nursing Director Completion Date: 04/30/2016 FollowUp: New referrals will be reviewed bythe Nursing Director at the weekly staff meeting to ensure that the initialvisit is being completed within 48hrs as required. The Nursing Director will review 10% or aminimum of 10 files quarterly to ensure compliance with this requirement. Anycontinued break in compliance may result in disciplinary action. This requirement will also be reviewed duringthe corporate compliance quarterly audit; Threshold for this is 100%.</p>		

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N 0441 Bldg. 00	<p>Survey dates: 4/4/16 - 4/8/16</p> <p>Facility #: 12050</p> <p>Medicaid Vendor #: 200942280</p> <p>Medicare #: 157629</p> <p>Skilled unduplicated census in the past 12 months: 68 patients</p> <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 record review and interview, the administrator failed to ensure that 1 of 1 agency did not delagate tasks to the corporate office of the agency.</p> <p>The findings include:</p> <p>1. Employee file O, Licensed Practical Nurse, with a date of hire 1/25/16 and no patient contact, failed to evidence a criminal history completed and in a personnel record.</p>			N 0441	<p>Background checks for all internal employees have been obtained from the corporate location as of 4/26/16. Going forward, the Administrator will ensure completion of criminal history checks on all applicants. The Administrator will review all back ground checks and have them secured in a locked cabinet in the office. All criminal background screenings will be given to the surveyor upon request by the Administrator per Indiana requirements.</p> <p>Responsible Party: Administrator</p>		04/26/2016

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N 0444 Bldg. 00	<p>2. Employee File P, Executive Director with a date of hire of 9/21/15 and no patient contact, failed to evidence a criminal history completed and in a personnel record.</p> <p>3. During an interview on 4/7/16 at 3:27 PM, Employee P, executive director, indicated the corporate office kept the criminal histories filed at the corporate office and not at the branch.</p> <p>4. The agency policy titled "Background Investigation" with a revised date of 10/2009 stated, "Criminal background screening for all applicants wishing to provide direct patient care."</p> <p>5. The agency policy titled "Licensure / Certification: Federal / State / Local Permits" with a date of 10/09 stated, "Each office will maintain compliance with all applicable local, state, and federal laws and regulations."</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</p>		<p>Completion Date: 4/26/16.</p> <p>Follow Up: The Regional Operations Director will review all new internal employee files to ensure compliance with above. This will be an ongoing process.</p>	

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	<p>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:</p> <p>(1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on record review and interview, the agency failed to ensure a single administrator organized and directed the agency's ongoing functions for 1 of 1 agency.</p> <p>The findings include:</p> <p>1. An organizational chart titled "Epic Health Services Valparaiso, IN" with no date evidenced Employee A was the administrator and Employee P was the executive director.</p> <p>2. On 4/6/16 at 10:41 AM, Employee P indicated she was in charge of the financial part of the agency and oversaw the management and scheduling part of the agency. She would move to the management position officially in September 2016 when she had the one year of experience. She stated, "The lines are blurred between [Employee A] and me. We are working together." Employee P indicated paperwork was pending since she had just started today.</p>	N 0444	<p>The Administrator reviewed and was educated on Administrator's job description and responsibilities by Regional Operation Director . Administrator signed the job description on 4/4/16.</p> <p>Going forward with any change in administrators meeting the state qualifications, the job description and duties will be clearly defined.</p> <p>Responsible Party: Regional Operations Director Completion Date: 4/20/16.</p> <p>Follow Up: The Regional Operations Director will be responsible for orientation and training of any new Agency Administrators.</p>	04/20/2016

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N 0458 Bldg. 00	<p>3. On 4/8/16 at 11:16 AM, Employee A indicated she was in charge of the daily operations of the agency and worked with Employee P concerning the operation of the agency.</p> <p>4. The personnel file for Employee A showed a job description titled "Administrator" with a date of 4/4/16 and signed by Employee A.</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: (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 record review and interview, the administrator failed to ensure the agency followed their policy for criminal history checks for 2 of 16 personnel records reviewed (Employees #0 and P).</p>	N 0458	Background checks for all internal employees have been obtained from the corporate location as of 4/26/16. Going forward, the Administrator will ensure completion of criminal history checks on all applicants. The Administrator will	04/26/2016	

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee file O, Licensed Practical Nurse, with a date of hire 1/25/16 and no patient contact, failed to evidence a criminal history completed and in a personnel record. 2. Employee File P, Executive Director with a date of hire of 9/21/15 and no patient contact, failed to evidence a criminal history completed and in a personnel record. 3. During an interview on 4/7/16 at 3:27 PM, Employee P, executive director, indicated the corporate office kept the criminal histories filed at the corporate office and not at the branch. 4. The agency policy titled "Background Investigation" with a revised date of 10/2009 stated, "Criminal background screening for all applicants wishing to provide direct patient care." 5. The agency policy titled "Licensure / Certification: Federal / State / Local Permits" with a date of 10/09 stated, "Each office will maintain compliance with all applicable local, state, and federal laws and regulations." 		<p>review all back groundchecks and have them secured in a locked cabinet in the office. All criminal background screenings will be given to the surveyor upon request by the Administrator per Indianarequirements. Responsible Party: Administrator Completion Date: 4/26/16. Follow Up: The Regional Operations Director will review all new internal employeefiles to ensure compliance with above. This will be an ongoing process</p>	

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N 0470 Bldg. 00	<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 home visit observation, interview, and record review, the agency failed to ensure staff had provided services in accordance with the agency's infection control policies and procedures in 5 of 5 home visits completed (#3, #4, #6, #7, #9).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During a home visit observation on 4/5/16 at 8:20 AM, Employee C, Registered Nurse (RN) was observed to enter the home of patient #3. She was observed to place her nursing bag on the floor. 2. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed at a home visit observation with patient #4. Her nursing bag was on the floor of the home. 	N 0470	<p>All employees observed during the home visits have been re-educated on hand washing/hand hygiene and infection control practices .The nursing director sent out hand washing and nursing bag policies to all field nurses via email and regular mail on 4/28/16. This information also included direction to notify the office if no handwashing supplies are available in the home.</p> <p>Nursing Supervisors will supervise nurses monthly doing home visits to ensure hand washing and nursing bag procedure is being followed. All nurses performing infusion services will be re-educated to the Agency's Infusion Therapy policies and procedures. Supervisory visits will be done during provision of infusion therapy services to observe the nurses' technique and documented on the supervisory visit note. Any continued break in infection control practices by any field staff will be documented as a disciplinary measure.</p>	04/30/2016

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	<p>3. During a home visit observation on 4/5/16 at 12 noon, Employee B, Home Health Aide, was observed to wash her hands with patient #9's bar soap and use the patient's hand towel to dry her hands before caring for patient #9.</p> <p>4. During an interview on 4/5/16 at 5 PM, Employee A indicated infection control procedures were not followed at the visit with Employee B at the home of patient #9. Employee A indicated the agency did not have a policy on a clean barrier with nursing bag use at home visits.</p> <p>5. During a home visit observation on 4/6/16 at 8:10 AM, Employee F, RN was observed to wash her hands with soap and then the kitchen towel by the kitchen sink prior to caring for patient #6.</p> <p>During an interview on 4/6/16 at 4:35 PM, Employee A, administrator, indicated the handwashing at the visit with Employee F's visit did not follow agency procedure.</p> <p>6. During a home visit observation on 4/7/16 at 1:45 PM, Employee E, Licensed Practical Nurse, was observed to terminate the patient #7's TPN (Total Parenteral Nutrition) treatment while the patient was sitting at a high chair tray</p>		<p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: QA nurse and Nursing Director will track compliance weekly and quarterly by doing chart audits. Date of correction- 4/27/16 .</p>	

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	<p>table. Employee E failed to clean the high chair table prior to completing the procedure.</p> <p>During an interview on 4/7/16 at 3:21 PM, Employee E agreed the agency procedure was not followed.</p> <p>7. An agency procedure titled "Infusion Therapy Self - Learning Module" with a date of 9/29/15 stated, "Hand hygiene is the single most effective way to prevent the spread of infection ... all medical procedures should be performed on a surface that is aseptic in the home setting ... maintaining an aseptic work area ... clean surface with bleach or antiseptic cleaner. Let surface dry ... cover area with available clean draping, cloth, diaper, towel, blue pad."</p> <p>8. The agency procedure titled "OSHA Training for Nursing New Hires" with no date stated, "Handwashing Technique ... Rinse hands thoroughly under running water ... apply nickel sized amount of hand rub / soap to the palm of hand ... vigorously rub hands together, scrubbing between fingers and up to wrists for 30 seconds ... rinse hands thoroughly under running water ... wipe hands using a clean towel.</p> <p>9. The agency document titled "Orientation Completion</p>			

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N 0484 Bldg. 00	<p>Acknowledgement - caregivers" with a revised date of 3/2012 evidenced Employees # C, D, E, and F received a copy of the nursing bag technique.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to evidence all personnel furnishing services documented the coordination of care while services were being provided for 3 of 13 records reviewed (#6, #8, #11).</p> <p>The findings include:</p> <p>Regarding clinical record #6</p> <p>1. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN,</p>	N 0484	<p>All Nursing Supervisors were re-educated on the Agency's policy for Care Coordination and Discharge by the Nursing Director.</p> <p>The Nursing Director will review all files of patients put on hold to ensure compliance with the Agency's policy's. All communications with physicians, family, and payers regarding the patient's care and service issues will be documented and placed in the patient record. Case conferences will be held for all patients at time of recertification and as needed. The case conferences will be documented on the Agency's case conference form and kept in the patient file. Completion Date: 4/30/16</p>	04/30/2016

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	<p>stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated patient #6 had been receiving pureed foods including cereals.</p> <p>3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as "restricted pureed."</p> <p>4. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>Concerning Clinical Record #8</p>		<p>Responsible Party: Nursing Director Follow Up: Caseconferences will be tracked by the QA nurse for completion atrecertification. Quarterly recordreviews of 10% or a minimum of 10 files will be done by the NursingDirector/Nursing Supervisors to ensure ongoing compliance with policy. Anybreak in policy found will result in re-education with any staff involved;continued non-compliance may result in disciplinary measures.</p>	

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	<p>5. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator, indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>6. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient is on hold but there is no documentation of communications between agency staff, the physician, the patient / patient caregiver, or others regarding the hold status and the reasons the patient has been placed on hold.</p> <p>7. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This physician's order was dated 4/1/16 and signed by Employee N, Registered Nurse. This document did not include any information about why the patient had been placed on hold or resumption of care plans.</p> <p>Regarding Clinical Record #11</p> <p>8. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8</p>			

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	<p>hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. The clinical record documentation failed to evidence the patient / informal caregiver had been informed about the patient's "On - Hold " Status. The physician had not informed about the resumption of care plans or the patient's need for the on hold services.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated, "Hold Home Health Services. This was signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>9. An agency document titled "Patient List" with a date of 4/4/16 evidenced</p>			

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	<p>patients #8 and #11 were on hold.</p> <p>10. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted and order received."</p> <p>11. The policy titled "Care Coordination" with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p>			

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N 0486 Bldg. 00	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on record review and interview, the agency failed to evidence all personnel furnishing services documented the coordination of care while services were being provided for 3 of 13 records reviewed (#6, #8, #11).</p> <p>The findings include:</p> <p>Regarding clinical record #6</p> <p>1. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated patient #6 had been receiving pureed foods including cereals.</p> <p>3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled</p>			N 0486	<p>All Nursing Supervisors were re-educated on the Agency's policy for Care Coordination and Discharge by the Nursing Director.</p> <p>The Nursing Director will review all files of patients put on hold to ensure compliance with the Agency's policy's. All communications with physicians, family, and payers regarding the patient's care and service issues will be documented and placed in the patient record. Case conferences will be held for all patients at time of recertification and as needed. The case conferences will be documented on the Agency's case conference form and kept in the patient file. Completion Date: 4/30/16 Responsible Party: Nursing Director Follow Up: Case conferences will be tracked by the QA nurse for completion at recertification. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>		04/30/2016

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	<p>nurse had documented nutritional intake as "restricted pureed."</p> <p>4. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>Concerning Clinical Record #8</p> <p>5. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator, indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>6. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient is on hold but there is no documentation of communications between agency staff, the physician, the patient / patient caregiver, or others</p>			

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	<p>regarding the hold status and the reasons the patient has been placed on hold.</p> <p>7. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This physician's order was dated 4/1/16 and signed by Employee N, Registered Nurse. This document did not include any information about why the patient had been placed on hold or resumption of care plans.</p> <p>Regarding Clinical Record #11</p> <p>8. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8 hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. The clinical record documentation failed to evidence the patient / informal caregiver had been informed about the patient's "On - Hold " Status. The physician had not informed about the resumption of care plans or the patient's need for the on hold services.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated, "Hold Home Health Services. This was</p>			

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	<p>signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>9. An agency document titled "Patient List" with a date of 4/4/16 evidenced patients #8 and #11 were on hold.</p> <p>10. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted and order received."</p> <p>11. The policy titled "Care Coordination" with a revised date of 5/2014 stated, "Interdisciplinary</p>			

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N 0505 Bldg. 00	<p>personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (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: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment.</p>			

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	<p>Based on record review and interview, the agency failed to ensure the patients were involved in planning for their discharge and care and had accurate knowledge of the care to be provided and right to be involved in planning changes in the care or treatment to be provided for 1 of 3 clinical records reviewed (#11) with patients listed as being "on hold."</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. This plan of care evidenced home health aide visits were to occur 8 hours a day 5 days a week. Home health visits occurred from 3/1/16 - 3/31/16. Patient #11 had been placed "On Hold" on 4/4/16 without the patient's knowledge. <p>A. A clinical record document titled "Home Care Consent" and signed by the patient on 3/1/16 evidenced the patient received the Patient Rights at the start of care.</p> <p>B. During an interview on 4/7/16 at 10:30 AM, the informal caregiver of patient #11 indicated the patient was discharged from the agency due to no</p>	N 0505	<p>All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy for Discharge. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/pcg, and payer regarding patient being placed on hold or discharged will be documented in the clinical record. Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/pcg, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	04/30/2016	

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	<p>coverage available from insurance payments.</p> <p>C. During an interview on 4/7/16 at 10:48 AM, Employee A, administrator, indicated the patient was not discharged but services had stopped due to the lack of Medicaid payment available at this time.</p> <p>2. An agency document titled "Patient List" with a date of 4/4/16 evidenced patient #11 was on hold and had been admitted to the agency on 3/1/16.</p> <p>3. The document titled "Patient Rights" with no date stated, "As our patient, you and your family have the right to be treated with dignity, courtesy, and respect ... make informed decisions about your care, to receive information to help make decisions and to participate in developing, planning, and changing your care plan ... receive reasonable continuity of care ... receive timely notice of impending discharge ... or to a different level of intensity of care."</p> <p>4. The policy titled "Discharge" with a revised date of 5/2014 stated, "On - Hold Status ... A case communication note is to be placed in the clinical record to document the patient's on hold status and reason. The physician will be contacted</p>			

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N 0520 Bldg. 00	<p>and order received."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on record review and interview, the agency failed to ensure patient needs were addressed and being met adequately in the patient's place of residence for 2 of 3 records reviewed (#8, #11) of patients placed on hold.</p> <p>Regarding clinical record #8</p> <p>1. Clinical record #8 was placed on hold on 4/1/16. The order for this "On Hold" was not completed per policy. There were no resumption of care plans on the "On Hold" order sent to the physician per policy.</p> <p>2. During an interview on 4/8/16 at 10:15 AM, Employee A, administrator,</p>	N 0520	<p>All Nursing Supervisors will be re-educated to the Agency's policy for Discharge and Physician's Orders. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/pcg, and payer regarding patient being placed on hold or discharged will be documented in the clinical record Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/pcg, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing</p>	04/30/2016

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	<p>indicated patient #8 is on hold due to the informal caregiver of patient #8 had not been given required documents to Medicaid as requested by the agency.</p> <p>3. During an interview on 4/8/16 at 10:25 AM, Employee A indicated this patient is on hold but there is no documentation of communications between agency staff, the physician, the patient / patient caregiver, or others regarding the hold status and the reasons the patient has been placed on hold.</p> <p>4. A clinical record document for patient #8 evidenced the patient had been placed on hold for skilled nurse services. This was dated 4/1/16 and signed by Employee N, Registered Nurse.</p> <p>Regarding clinical record #11</p> <p>5. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. The care for this patient started on 3/1/16 and not 2/16/16. An initial assessment visit on 3/1/16 and home health aide visits occurred on 3/1/16, 3/2/16, 3/3/16, 3/4/16, 3/11/16, 3/14/16, 3/15/16, 3/16/16, 3/17/16, 3/21/16, 3/22/16, 3/23/16, 3/24/16, 3/25/16, 3/28/16,</p>		Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.	

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	<p>3/29/16, and 3/30/16. This patient was placed on hold on 4/1/16. The reason for the on hold status was not on the order sent to the physician.</p> <p>A. A document titled "Physician's Orders" with a date of 4/1/16 stated, "Hold Home Health Services. This was signed by Employee M, RN. The reason the hold order was in place and plans for the resumption of care were not shared with the physician</p> <p>B. During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the certification period was in error and that the patient had been placed on hold.</p> <p>6. The agency policy titled "Physician's Order" with a revised date of 5/2014 stated, "Physician's orders must be obtained for services ... by all health care personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs. It includes all pertinent diagnosis, surgical history ... types of services and equipment required. hours or frequency of visits / shifts ... the company plan of treatment form will be used ... the plan of treatment will be reviewed and revised as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2016
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N 0522 Bldg. 00	<p>needed and at least every 60 days and as necessary based on state requirement ... when a patient is placed on hold, there must be an order to the physician declaring that services are being held, why, and plan for resumption. The POC must continue to be submitted to the physician for signature, noting on there that the physician is on hold and the reason."</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 record review and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 5 of 13 records reviewed (#1, #3, #4, #6, #12).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care (SOC) 1/5/12 and diagnosis of muscular dystrophy, included a plan of care for the certification period of 2/7/16 - 4/6/16 and included orders for the skilled nurse to visit 11 - 13 hours a day 5 - 7 days a</p>	N 0522	All field nurses were re-educated via email and regular mail information regarding the requirement of following the POC and if any orders were questionable, then they are to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that	04/30/2016

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	<p>week. The orders evidenced the skilled nurse was to complete cough assist treatment daily and CPT (chest percussion therapy) vest treatment daily prior to cough assist.</p> <p>A. A skilled nursing flowsheet dated 3/9/16 and signed by Employee R, Licensed Practical Nurse (LPN) evidenced the CPT Vest treatment and cough assist were not completed as ordered.</p> <p>B. A skilled nursing flowsheet dated 3/12/16 and signed by Employee T, Registered Nurse (RN), evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>C. A skilled nursing flowsheet dated 3/13/16 and signed by Employee S, LPN, evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>D. A skilled nursing flowsheet dated 3/16/16 and signed by Employee R, LPN, evidenced the CPT vest treatment was not completed as ordered.</p> <p>E. On 4/6/16 at 1:40 PM, Employee U, RN, indicated the above visits did not follow the plan of care.</p>		<p>needclarification or change will be communicated to the physician. Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each workingnurse/aide documentation each week to ensure compliance with POC. This willoccur for 4weeks; then each working nurse/aide will have 25% of theirdocumentation reviewed each week. During quarterly record review the NursingDirector will review 10% of census or a minimum of 10 files for compliance withthis requirement. These requirementswill also be reviewed during the corporate compliance quarterly audits. Thethreshold for these audits is 100%.</p>	

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	<p>2. Clinical record #3, start of care 5/1/12 and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care evidenced the patient was to be weighed weekly and results called to a home care pharmacy company. No weights were documented from 2/23/16 - 3/21/16 as evidenced below:</p> <p>A. A skilled nursing flowsheet with a date of 2/23/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>B. A skilled nursing flowsheet with a date of 2/25/16 and sinuate of Employee C, RN evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>C. A skilled nursing flowsheet with a date of 3/1/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>D. A skilled nursing flowsheet with a date of 3/3/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p>			

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	<p>E. A skilled nursing flowsheet with a date of 3/8/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>F. A skilled nursing flowsheet with a date of 3/15/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>G. A skilled nursing flowsheet with a date of 3/17/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>H. A skilled nursing flowsheet with a date of 3/22/16 and signature of Employee C, RN, evidenced the patient was weighed and the results were called to the pharmacy.</p> <p>I. During an interview on 4/7/16 at 4:20 PM, Employee A, administrator, indicated there was a lack of documentation with the weekly weights to be completed for this patient.</p> <p>3. Clinical record #4, start of care</p>			

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	<p>3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for a oxygen saturation rate to be taken at each visit. Oxygen saturation rates were not documented for visits on 3/24/16, 3/25/16, 3/29/16, and 4/1/16 by the skilled nurses.</p> <p>On 4/7/16 at 4:10 PM, Employee A, administrator, indicated the plan of care had not been followed at the above visits.</p> <p>4. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior and not Elecare as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the</p>			

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	<p>patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the care did not follow the plan of care for this record.</p> <p>5. Clinical record #12, start of care 2/12/16 and diagnosis of Type 2 Diabetes, included a plan of care for the certification period of 2/8/16 - 4/7/16. The verbal start of care date was 1/26/16 and the physician signed on the same date. There was no frequency or duration on this plan of care for often the home health aide was to visit. An initial assessment was completed on 2/1/16. Home health aide visits occurred from 2/13/16 - 3/26/16 except on 2/14/16, 2/21/16, 2/28/16, 3/6/16, 3/13/16, and 3/20/16. Tasks completed included a partial bed bath, mouth care set -up, assist with dressing, assisting to the toilet and changing briefs.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the plan of care was not accurate.</p> <p>6. The agency policy titled "Physician's</p>			

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N 0524 Bldg. 00	<p>Orders" with a revised date of 4/2014 stated, "Physician's orders must be obtained for services ... by all healthcare personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or</p>			

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	<p>referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the plan of care was accurate for 5 of 13 clinical records reviewed (#3, #4, #6, #11, #12).</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #3, start of care 5/1/12 and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care was for 90 day period instead of a 60 day period. <p>During an interview on 4/6/16 at 3 PM, Employee A, the administrator, indicated the certification period was for 90 days instead of 60 days.</p> <ol style="list-style-type: none"> Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 failed to evidence an individualized patient plan of care as evidenced by the lack of updated orders and vital sign parameters. The plan of care / physician orders failed to include orders to feed the patient via a infant bottle Simalac. This was evidenced by the following: 	N 0524	<p>All Nursing Supervisors will be re-educated to the Agency's policy for Discharge and Physician's Orders. The Nursing Supervisors will review all patients needing to be placed on hold with the Nursing Director to ensure the Agency's policy is being followed. All communication with physician, family/pcg, and payer regarding patient being placed on hold or discharged will be documented in the clinical record</p> <p>Responsible Party: Nursing Director, Nursing Supervisors</p> <p>Completion Date: 4/30/16</p> <p>Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/pcg, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	04/30/2016	

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	<p>A. A clinical record document titled "Home Health Certification and Plan of Care" for the certification period of 3/12/16 - 5/10/16 stated, "Vital Sign Parameters [Patient Specific] ... notify MD [medical doctor] and / or RN supervisor for any VS [vital signs] outside listed parameters greater than 30 - 60 minutes greater than 30 - 60 minutes post intervention that are not resolved ... Skilled nurse to maintain NG [nasogastric] tube placement via aspiration and auscultation prior to administration of feeds and medications ... SN to bathe / shower patient every shift and prn."</p> <p>B. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed to feed 1 ounce of formula which included the patient's liquid medications: Phenobarbital and a multi vitamin with iron.</p> <p>C. On 4/7/16 at 4:30 PM, Employee A, administrator, indicated the plan of care had not been individualized for patient #4's medical care nor updated with the patient's current nutritional orders. Employee A indicated the computer program had an automatic click that probably produced the bathe / shower order and indicated this patient</p>			

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	<p>would not be appropriate to shower.</p> <p>3. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior and not Elecare as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the plan of care had not been updated.</p>			

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	<p>4. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, included a plan of care for the certification period of 2/16/16 - 4/15/16. The care for this patient started on 3/1/16 and not 2/16/16. An initial assessment visit on 3/1/16 and home health aide visits occurred on 3/1/16, 3/2/16, 3/3/16, 3/4/16, 3/11/16, 3/14/16, 3/15/16, 3/16/16, 3/17/16, 3/21/16, 3/22/16, 3/23/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, and 3/30/16.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the certification period was in error.</p> <p>5. Clinical record #12, start of care 2/12/16 and diagnosis of Type 2 Diabetes, included a plan of care for the certification period of 2/8/16 - 4/7/16. The verbal start of care date was 1/26/16 and the physician signed on the same date. There was no frequency or duration on this plan of care for often the home health aide was to visit. An initial assessment was completed on 2/1/16. Home health aide visits occurred from 2/13/16 - 3/26/16 except on 2/14/16, 2/21/16, 2/28/16, 3/6/16, 3/13/16, and 3/20/16. Tasks completed included a partial bed bath, mouth care set -up,</p>			

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N 0529 Bldg. 00	<p>assist with dressing, assisting to the toilet and changing briefs.</p> <p>During an interview on 4/7/16 at 10:48 AM, Employee A, the administrator, indicated the plan of care was not accurate.</p> <p>6. The agency policy titled "Physician's Order" with a revised date of 5/2014 stated, "Physician's orders must be obtained for services ... by all health care personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs. It includes all pertinent diagnosis, surgical history ... types of services and equipment required. hours or frequency of visits / shifts ... the company plan of treatment form will be used ... the plan of treatment will be reviewed and revised as needed and at least every 60 days and as necessary based on state requirement."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p>			

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	<p>Based on interview and record review, the home health agency failed to ensure 60 day summaries sent to the physician included a description of the patient's current condition and the patient's progress for 3 of 6 records reviewed of services provided over 60 days (#1, #3, #7).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care 1/5/12, failed to evidence the 60 day summary had been updated with the patient's current condition and care provided for the certification periods of 12/9/15 - 2/6/16 and 2/7/16 - 4/6/16.</p> <p>The 60 day summary provided to the physician on the plan of care for the certification period of 2/7/16 - 4/16/16 stated, "60 day summary date of last physician visit: N/A [not applicable], date of hospitalization: 1/5/16, emergency room visit: N / A, New medication orders: naproxen and pepcid, change in patient condition: none at this time, patient remains homebound due to: N / A." There was no report of progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p>	N 0529	<p>All Nursing Supervisors were re-educated on the Agency's policy for Care Coordination. Information regarding the patient's progression to goals, status of problems, and a summary of care will be provided to the physician with each recertification. Responsible Party: Nursing Director Completion Date: 4/30/16 Follow Up: The Nursing Director will review 10% or a minimum of 10 files quarterly to ensure compliance with this requirement. Any continued break in compliance may result in disciplinary action. This requirement will also be reviewed during the corporate compliance quarterly audit; Threshold for this is 100%.</p>	04/30/2016	

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	<p>2. Clinical record #3, start of care 5/1/12 failed to evidence the 60 day summary had been updated with the patient's current condition and care provided between the certification periods of 2/26/15 - 2/22/16 and 2/23/16 - 5/16/16.</p> <p>A. The 60 day summary on the plan of care from 2/23/16 - 5/16/16 stated, "Date of last physician visit 3/11/2016, date of hospitalization: 1/4/16, emergency room visit 12/22/15, new medication order: none at this time, change in patient condition: none at this time, patient remains homebound at this time: N/A" There was no report of progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p> <p>3. Clinical record #7, start of care 5/21/15 failed to evidence the 60 day summary had been updated with the patient's current condition and care provided between the certification periods of 1/12/16 - 3/11/16 and 3/12/16 - 5/10/16</p> <p>A. The 60 day summary on the plan of care from 3/12/16 - 5/10/16 stated, "Date of last physician visit unknown, date of hospitalization: 2/29/16 -3/2/16 ,</p>			

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	<p>emergency room visit 2/29/16, new medication order: yes, change in patient condition: no." There was no report of the medication changes or the progress toward the achievement of anticipated outcomes during the course of care or the patient / family response to the care and services provided.</p> <p>4. The agency policy titled "Care Coordination" with a revised date of 5/2014 stated, "The clinical manager or designee will send the physician a written summary, at least every 60 days ... the written summary to the physician includes a. a report of progress toward achievement of anticipated outcomes during the previous certification period for all services, b. The status of problems throughout the course of care c. A summary of care provided d. Status of progress towards goals during the previous period e. Patient and family response to the care and services provided.</p> <p>5. During an interview, on 4/7/16 at 3:50 PM, Employee A, administrator, indicated the 60 day summaries were not complete.</p>			

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N 0537 Bldg. 00	<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 record review and interview, the agency failed to ensure the skilled nurse provided care in accordance with physician orders in 4 of 7 records reviewed with skilled nursing (#1, #3, #4, #6).</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of care (SOC) 1/5/12 and diagnosis of muscular dystrophy, included a plan of care for the certification period of 2/7/16 - 4/6/16 and included orders for the skilled nurse to visit 11 - 13 hours a day 5 - 7 days a week. The orders evidenced the skilled nurse was to complete cough assist treatment daily and CPT (chest percussion therapy) vest treatment daily prior to cough assist.</p> <p>A. A skilled nursing flowsheet dated 3/9/16 and signed by Employee R, Licensed Practical Nurse (LPN) evidenced the CPT Vest treatment and cough assist were not completed as ordered.</p>			N 0537	<p>All field nurses were re-educated via email and regular mail information regarding the requirement of following the POC and if any orders were questionable, then they are to clarify those orders with the doctor. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician. Responsible Party: Nursing Director/Nursing Supervisors Completion Date: 4/30/16 Follow Up: The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each working nurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this</p>		04/30/2016

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	<p>B. A skilled nursing flowsheet dated 3/12/16 and signed by Employee T, Registered Nurse (RN), evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>C. A skilled nursing flowsheet dated 3/13/16 and signed by Employee S, LPN, evidenced the CPT vest treatment and cough assist were not completed as ordered.</p> <p>D. A skilled nursing flowsheet dated 3/16/16 and signed by Employee R, LPN, evidenced the CPT vest treatment was not completed as ordered.</p> <p>E. On 4/6/16 at 1:40 PM, Employee U, RN, indicated the above visits did not follow the plan of care.</p> <p>2. Clinical record #3, start of care 5/1/12 and diagnosis of cerebral palsy, included a plan of care for the certification period of 2/23/16 - 5/15/16. This plan of care evidenced the patient was to be weighed weekly and results called to a home care pharmacy company. No weights were documented from 2/23/16 - 3/21/16 as evidenced below:</p> <p>A. A skilled nursing flowsheet with a date of 2/23/16 and signature of Employee C, RN, evidenced the patient</p>		<p>requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%.</p>	

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	<p>was not weighed and no results were called to the home care pharmacy company.</p> <p>B. A skilled nursing flowsheet with a date of 2/25/16 and sinuate of Employee C, RN evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>C. A skilled nursing flowsheet with a date of 3/1/16 and signature of Employee C, RN, evidenced the patient was not weighed and no results were called to the home care pharmacy company.</p> <p>D. A skilled nursing flowsheet with a date of 3/3/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>E. A skilled nursing flowsheet with a date of 3/8/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>F. A skilled nursing flowsheet with a date of 3/15/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p>			

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	<p>G. A skilled nursing flowsheet with a date of 3/17/16 and signature of Employee C, RN, evidenced the patient was not weighed and the results were not called to the home care pharmacy company.</p> <p>H. A skilled nursing flowsheet with a date of 3/22/16 and signature of Employee C, RN, evidenced the patient was weighed and the results were called to the pharmacy.</p> <p>I. During an interview on 4/7/16 at 4:20 PM, Employee A, administrator, indicated there was a lack of documentation with the weekly weights to be completed for this patient.</p> <p>3. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for a oxygen saturation rate to be taken at each visit. Oxygen saturation rates were not documented for visits on 3/24/16, 3/25/16, 3/29/16, and 4/1/16 by the skilled nurses.</p> <p>On 4/7/16 at 4:10 PM, Employee A, administrator, indicated the plan of care had not been followed at the above visits.</p>			

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	<p>4. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecure Junior and not Elecure as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecure Jr.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecure Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the care did not follow the plan of care for this record.</p> <p>5. The agency policy titled "Physician's Orders" with a revised date of 4/2014 stated, "Physician's orders must be</p>			

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N 0540 Bldg. 00	<p>obtained for services ... by all healthcare personnel as required by state regulation ... the plan of treatment is developed based on an evaluation of the patient's immediate and long - term needs."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) accurately and completely evaluated the patient for the start of care assessment in 2 of 13 records reviewed (#9, #11).</p> <p>The findings include:</p> <p>1. Clinical record #9, start of care 1/27/16 and diagnosis of Type 2 Diabetes, evidenced an initial assessment completed by the RN on 1/27/16. This assessment failed to evidence a blood pressure had been completed at this visit.</p> <p>During an interview on 4/8/16 at 3:10 PM, Employee A, administrator,</p>	N 0540	<p>All nursing supervisor were re-educated by the NursingSupervisor on the requirement of completing and documenting a comprehensiveassessment during all patient visits. The Nursing Supervisors will be educated toreview all documentation for accuracy and completion prior to entering it intothe patient's record.</p> <p>..</p> <p>Responsible Party: Nursing Director Completion Date: 4/30/16 Follow Up: The Nursing Director will review 10% or a minimumof 10 files quarterly to ensure compliance with this requirement. Any continuedbreak in compliance may result in disciplinary action. This requirement will also be reviewed duringthe corporate compliance</p>	04/30/2016

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N 0545 Bldg. 00	<p>indicated the assessment was not complete.</p> <p>2. Clinical record #11, start of care 3/1/16 and diagnosis of diffuse traumatic brain injury, evidenced an initial assessment completed by the RN on 3/1/16. This assessment failed to evidence the height, weight, and blood pressure had been completed at this visit.</p> <p>On 4/8/16 at 10:38 AM, Employee A, administrator, indicated the initial assessment was not complete.</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on record review and interview, the agency failed to evidence the registered nurse documented the coordination of care while services were being provided for 1 of 7 records reviewed of patients with skilled nursing services (#6).</p> <p>The findings include:</p> <p>1. Clinical record #6 included a</p>	N 0545	<p>quarterly audit; Threshold for this is 100%.</p> <p>All Nursing Supervisors were re-educated by the Nursing Director on the Agency's policy for Care Coordination and the need to document communication with all team members caring for the patient in the patient's medical file. Responsible Party: Nursing Director Completion Date: 4/30/16 Follow Up: The Nursing Director will review 10% or a minimum of 10 files quarterly to ensure compliance with this requirement. Any continued break in compliance may</p>	04/30/2016

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	<p>physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient #6 had been receiving pureed foods including cereals.</p> <p>3. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as "restricted pureed."</p> <p>4. During an interview on 4/6/16 at 11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>5. The policy titled "Care Coordination"</p>		result in disciplinary action.	

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N 0556 Bldg. 00	<p>with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>410 IAC 17-14-1(a)(2)(D) Scope of Services Rule 14 Sec. 1(a) (2)(D) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (D) Prepare equipment and materials for treatments observing aseptic technique as required.</p> <p>Based on record review, home visit observation, and interview, the licensed practical nurse failed to establish an aseptic field while completing a treatment for 1 of 1 home visit observations with a licensed practical nurse (Employee E with patient #7).</p> <p>The findings include:</p> <p>1. During a home visit observation on 4/7/16 at 1:45 PM, Employee E, Licensed Practical Nurse, was observed to terminate the patient #7's TPN (Total</p>	N 0556	<p>All nurses performing infusion services will be re-educated by the Nursing Supervisor and/or Nursing Director to the Agency's Infusion Therapy policies and procedures. Supervisory visits will be done during provision of infusion therapy services to observe the nurses' technique and documented on the supervisory visit note. Any continued break in infection control practices by any field staff will be documented as a disciplinary measure.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 4/30/16</p>	04/30/2016

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N 0589 Bldg. 00	<p>Parenteral Nutrition) treatment while the patient was sitting at a high chair tray table. Employee E failed to clean the high chair table prior to completing the procedure.</p> <p>During an interview on 4/7/16 at 3:21 PM, Employee E agreed the agency procedure was not followed.</p> <p>2. An agency procedure titled "Infusion Therapy Self - Learning Module" with a date of 9/29/15 stated, "Hand hygiene is the single most effective way to prevent the spread of infection ... all medical procedures should be performed on a surface that is aseptic in the home setting ... maintaining an aseptic work area ... clean surface with bleach or antiseptic cleaner. Let surface dry ... cover area with available clean draping, cloth, diaper, towel, blue pad."</p> <p>410 IAC 17-14-1(i) Scope of Services Rule 14 Sec. 1(i) During a home health aide's first year on the state's home health aide registry, the number of hours of training for that aide shall be a prorated portion of the usual twelve (12) and eight (8) hours. Based on interview and record review, the agency failed to ensure 2 of 3 home health aide files (Y and Z) reviewed of aides hired in 2015 had completed the required number of inservices for 2015.</p>	N 0589	<p>Follow Up: Nursing Director will review all supervisory visits done to observe provision of infusion therapy to ensure documentation of compliance with policy/procedures for 1 month; ongoing the Nursing Director will randomly review supervisory visits done for patients receiving infusion services to ensure ongoing compliance.</p> <p>Nursing Supervisors and any internal staff that monitor the employee's compliance with the inservice regulation will be re-educated by the Nursing Director on the requirement for Home Health Aides to receive 12hrs of inservice education within a calendar year. All</p>	05/15/2016	

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N 0596 Bldg. 00	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The personnel file for Employee Y, date of hire 8/26/15, failed to evidence she attended any inservices in 2015. 2. The personnel file for Employee Z, date of hire 10/29/15 failed to evidence she attended any inservices in 2015. 3. During an interview, on 4/8/16 at 3 PM, Employee A, administrator, indicated Employee Y and Z did not attend enough inservices in 2015. 4. The agency policy titled "Licensure / Certification: Federal / State / Local Permits" with a date of 10/09 stated, "Each office will maintain compliance with all applicable local, state, and federal laws and regulations." <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</p>		<p>Home Health Aide employee files will be reviewed to ensure compliance with this regulation for the calendaryear 2015. Any aides that have not completed the required inservices will be notified and brought into the Agency for completion. A sign in sheet documenting attendance at anyon site inservices will be maintained for all inservices presented. Any inservices done by reading and testing will be documented on an answer sheet with the name of the inservices, date completed, name of employee, and number of credit hours given. All documentation of inservices will be placed in the employee file. Responsible Party: Nursing Director, Administrator Completion date: 5/15/16 Follow Up: The Administrator/designee will do a quarterly audit of 10% of all home health aide files to ensure ongoing compliance. This requirement will also be reviewed during the corporate compliance quarterly audit for a threshold of 100%</p>		

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	<p>competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on record review and interview, the agency failed to evidence 4 of 5 home health aides (#G, #H, #J, #K) were evaluated for competency in each bathing skill performed for patients with that skill assigned.</p> <p>The findings include:</p> <p>1. The file for employee G, date of hire 12/10/15 and first patient contact date 1/11/16, contained Employee G's skills competency sheet. The Home Health Aide Competency Evaluation dated 12/10/15 and 1/11/16 failed to evidence that Employee G was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care, oral hygiene. This document was signed by Employee G on 12/10/15, Employee N, Registered Nurse on 12/10/15, and Employee L, RN on 1/11/16. The only task on this list observed and evaluated as competent was documents and reports observation of client status and care rendered.</p> <p>Clinical record #9 evidenced Employee G had given patient #9 a shower on 2/23/16 and 2/26/16. Employee G had not been deemed</p>	N 0596	<p>All Nursing Supervisors will be re-educated by the Nursing Director to the Agency's policy Home Health Aide Competency Evaluation and Training. All Home Health Aide files will be reviewed to ensure competency documented for all skills. Any found deficient will be brought in to the Agency for retraining and observation of skills competency. This will be documented on the Home Health Aide competency form.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors Completion Date: 5/1/16 Follow Up: The Nursing Director will review the files for documentation of skills competency of any new home health aides hired until 6/30/16. After this a random review will be done to ensure ongoing compliance. This requirement is also reviewed during the corporate compliance quarterly audit with a threshold of 100%.</p>	05/01/2016

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	<p>competent in showering a patient.</p> <p>2. The file for employee H, date of hire 1/19/16 and first patient contact date 2/19/16, contained Employee H's skills competency sheet. The Home Health Aide Competency Evaluation dated 1/19/16 and 2/19/16 failed to evidence that Employee H was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care, and oral hygiene. This document was signed by Employee H on 1/19/16 and Employee L on 1/19/16 and 2/19/16. The only tasks that were observed and showed that the employee was competent were personal hygiene related to toileting and elimination, safe transfers and ambulation techniques, and communication skills.</p> <p>Clinical record #10 evidenced that on 2/21 - 2/26/16 Employee H have gave patient #10 bed baths and sponge baths to this patient. Employee H had not been deemed competent in these tasks.</p> <p>3. The file for Employee J, date of hire 11/19/15 and first patient contact date 12/2/15, contained Employee J's skills competency sheet. The Home Health Aide Competency evaluation dated 11/19/15 and signed by Employee J and Employee A, administrator on 11/19/15</p>				

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	<p>and Employee L on 11/27/15 failed to evidence that Employee J was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care and oral care.</p> <p>Clinical record #13 evidenced Employee J assisted patient #13 with a shower on 12/11/15.</p> <p>4. The file for employee K, date of hire 8/20/15 and first patient contact date 8/21/15, contained Employee H's skills competency sheet. The Home Health Aide Competency Evaluation dated 8/21/15 failed to evidence that Employee H was observed and competent in giving bed baths, sponge baths, tub baths, showers, shampooing, nail / skin care, and oral hygiene. This document was signed by Employee K on 1/19/16 and Employee L on 8/21/15.</p> <p>Clinical record #12 evidenced Employee K gave partial bed baths to patient #12 on 2/22/16, 2/23/16, and 2/25/16.</p> <p>5. The agency policy titled "Home Health Aide Competency Evaluation and Training" with a revised date of 10/2009 stated, "Home Health aides ... must show acceptable proof of having passed any</p>			

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N 0606 Bldg. 00	<p>training and / or testing required by federal / state regulation or pass the Company training and / or testing program that meets the requirements prior to assignment ... if a home health aide does not present appropriate documentation of the above requirements they must complete the approved company training and competency program."</p> <p>6. During an interview on 4/8/16 at 9:35 AM, the administrator indicated the home health aide competencies did not evidence the home health aides were competent in the tasks they were completing.</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 (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. Based on record review and interview, the agency failed to ensure the registered nurse (RN) made an on - site visit to the patient's home no less frequently than every 30 days in 1 of 5 records reviewed of patients receiving home health aide only services (#9) for over 30 days.</p>	N 0606	All nursing supervisors re-educated by the Nursing Director to the State regulation 410 IAC 17-14-1 (n) which states that home health aide supervisory visits are every 30 days which supercedes the Federal and Agency Policy. A tracking mechanism will be put into place to ensure that all home health aides are supervised	04/30/2016

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N 0608 Bldg. 00	<p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #9, start of care 1/27/16 and diagnosis of Type 2 Diabetes, included plans of care for the certification period of 1/27/16 - 3/26/16 and 3/27/16 - 6/18/16 with home health aide services two hours a day with 4 days a week and home health aide visits were completed from the start of care. A clinical record document showed an aide supervisory visit on 3/1/16 completed by Employee L, RN. There were no other aide supervisory visits in this record. On 4/5/16 at 3:05 PM, Employee L, RN, indicated there were supervisory visits were not done every 30 days. <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:</p> <ol style="list-style-type: none"> The medical plan of care and appropriate identifying information. Name of the physician, dentist, chiropractor, podiatrist, or optometrist. Drug, dietary, treatment, and activity orders. 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. Copies of summary reports sent to the 		<p>as per regulation. Responsible Party: NursingDirector Completion Date: 4/30/16 Follow Up: Nursing Director and/or Administrator will review the tracking on a weekly basis for 60 days to ensure that all required home health supervisions are being completed as per regulation. After this a random review will be done to ensure ongoing compliance. This requirement is also reviewed during the corporate compliance quarterly audit with a threshold of 100%.</p>				

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	<p>person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to maintain clinical records in accordance with its own policy in 3 of 13 records reviewed (#2, #4, #6)</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care (SOC) 11/2/12 and diagnosis of other congenital malformation of the spine not associated with scoliosis, included a skilled visit note on 3/15/16 completed by Employee V, licensed practical nurse, which evidenced the patient received water and Kid Essent in the amount of 105 milliliters at 5 PM. This amount was written over the numbers "100" with both entries.</p> <p>During a interview on 4/7/16 at 1 PM, Employee M, Registered Nurse, indicated the clinical documentation was not corrected per agency policy.</p> <p>2. Clinical record #4, start of care 3/12/16 diagnosis of gestational preterm newborn, included a plan of care for the certification period of 3/12/16 - 5/10/16 failed to evidence an individualized patient plan of care as evidenced by the lack of updated orders and vital sign</p>	N 0608	<p>All field nurses were educated via email and regular mail to the Agency's Clinical Record policy. During home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by the Nursing Director to the Agency policy for Physician's Orders and the need to review all orders prior to sending to MD for accuracy and completeness. During all home visits, the POC will be reviewed with the staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be communicated to the physician. Responsible Party: Nursing Director, Nursing Supervisor Completion Date: 4/30/16 Follow Up: During the weekly clinical team meetings, all patients on hold will be discussed to ensure on-going communication is being completed with physician, family/pcg, and payer as applicable. Quarterly record reviews of 10% or a minimum of 10 files will be done by the Nursing Director/Nursing Supervisors to ensure ongoing compliance with policy. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	04/30/2016

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	<p>parameters. The plan of care / physician orders failed to include orders to feed the patient via a infant bottle Simalac. This was evidenced by the following:</p> <p>A. A clinical record document titled "Home Health Certification and Plan of Care" for the certification period of 3/12/16 - 5/10/16 stated, "Vital Sign Parameters [Patient Specific] ... notify MD [medical doctor] and / or RN supervisor for any VS [vital signs] outside listed parameters greater than 30 - 60 minutes greater than 30 - 60 minutes post intervention that are not resolved ... Skilled nurse to maintain NG [nasogastric] tube placement via aspiration and auscultation prior to administration of feeds and medications ... SN to bathe / shower patient every shift and prn."</p> <p>B. During a home visit observation on 4/5/16 at 9:45 AM, Employee D, RN, was observed to feed 1 ounce of formula which included the patient's liquid medications: Phenobarbital and a multi vitamin with iron.</p> <p>C. On 4/7/16 at 4:30 PM, Employee A, administrator, indicated the plan of care had not been individualized for patient #4's medical care nor updated with the patient's current nutritional</p>			

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	<p>orders. Employee A indicated the computer program had an automatic click that probably produced the bathe / shower order and indicated this patient would not be appropriate to shower.</p> <p>3. Clinical record #6, start of care 2/20/15 and diagnoses of other chronic respiratory diseases originating in the perinatal period, extremely low birth weight, atrial septal defect, and cardiomegaly, included a plan of care for the certification period of 3/12/16 - 5/10/16 with orders for the skilled nurse to visit 6 - 8 hours a day 5 - 7 days a week. The skilled nurse was to change the trach every week and prn for dislodgement and occlusion and to apply a cardiac apnea monitor and have on the patient at all times . The patient was receiving Elecare Junior and not Elecare as ordered on the plan of care. Skilled nurse visits on 3/21/16, 3/25/16, 3/28/16, 3/29/16, and 4/1/16 evidenced the patient was receiving Elecare Jr. On 3/4/16, 3/16/16, 3/17/16, 3/18/16, 3/22/16, 3/23/16, 3/24/16, 3/30/16, and 3/31/16, the skilled nurse documented the patient received Elecare. The physician had given an order for pureed diet to be given to the patient if the speech therapist cleared the patient. There was no documentation that the speech therapist</p>			

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	<p>had cleared the patient but the patient had received the upgraded diet at skilled nurse visits.</p> <p>A. On 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the patient no longer was on a Cardiac apnea monitor and indicated patient #6 had been discontinued from this monitor since November 2015. The patient is now on Elecare Junior. The caregiver indicated being responsible for the routine trach changes every week.</p> <p>B. Clinical record #6 included a physician's order dated 3/3/16 and signed by the physician and Employee M, RN, stated, "Nurses may give pureed food to patient as long as it is cleared by speech therapy."</p> <p>1. Skilled nurse visits on 3/14/16, 3/17/16, 3/18/16, 3/21/16, 3/22/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, and 4/1/16 evidenced the skilled nurse had documented nutritional intake as restricted pureed.</p> <p>2. During an interview on 4/6/16 at 8:15 AM, the caregiver of patient #6 indicated the caregiver of patient #6 had been receiving pureed foods including cereals.</p> <p>C. On 4/6/16 at 11:45 AM, Employee M, RN, indicated the documentation was not accurate for this record.</p> <p>D. During an interview on 4/6/16 at</p>			

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	<p>11:45 AM, Employee M, RN, indicated the patient had been seen by a speech therapist from a different agency. The Speech Therapist had given verbal permission for the patient to have pureed food at a visit that Employee M was present on March 10, 2016. Employee M indicated that there was no documentation that the speech therapist had visited or what had occurred or been said to upgrade the diet to pureed and to allow the skilled nurses to give this to the patient.</p> <p>4. The policy titled "Care Coordination" with a revised date of 5/2014 stated, "Interdisciplinary personnel internal as well as external to the company must maintain close communication to ensure that each patient receive coordinated, complimentary care that meets his or her needs and supports the objectives identified in the plan of care ... all communication will be documented in the clinical record."</p> <p>5. The policy titled "Clinical Records" with a date of 5/2014 stated, "Original, complete, accurate, and confidential clinical records will be maintained on all patients ... the clinical record in the branch is a legal document. All information must be entered accurately, legibly, and signed with the clinician's legal name and title. Corrections and additions to clinical record</p>			

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N 0610 Bldg. 00	<p>documentation will be entered only in a legally acceptable manner."</p> <p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on record review and interview, the agency failed to ensure all entries for each clinical record were legible, clean, and appropriately authenticated and dated for 1 of 13 records reviewed (#2).</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care (SOC) 11/2/12 and diagnosis of other congenital malformation of the spine not associated with scoliosis, included a skilled visit note on 3/15/16 completed by Employee V, licensed practical nurse, which evidenced the patient received water and Kid Essent in the amount of 105 milliliters at 5 PM. This amount was written over the numbers "100" with both entries.</p> <p>During a interview on 4/7/16 at 1 PM, Employee M, Registered Nurse,</p>	N 0610	<p>All field nurses were educated via email and regular mail to the Agency's Clinical Record policy. During home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Responsible Party: Nursing Director Completion Date: 4/30/16 The QA Nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC. This will occur for 4 weeks; then each working nurse/aide will have 25% of their documentation reviewed each week. During quarterly record review the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement.</p>	04/30/2016

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	<p>indicated the clinical documentation was not corrected per agency policy.</p> <p>2. The policy titled "Clinical Records" with a date of 5/2014 stated, "Original, complete, accurate, and confidential clinical records will be maintained on all patients ... the clinical record in the branch is a legal document. All information must be entered accurately, legibly, and signed with the clinician's legal name and title. Corrections and additions to clinical record documentation will be entered only in a legally acceptable manner."</p>			