

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157559	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2012
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NAME OF PROVIDER OR SUPPLIER HEALTHSET	STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714
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G0000	<p>This was a federal home health recertification survey. Extended Survey 9-18-12, 9-19-12, and 9-20-12</p> <p>Facility #: 003563</p> <p>Survey Dates: 9-18-12, 9-19-12, and 9-20-12</p> <p>Medicaid Vendor #: 200450280A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Healthset is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 9-20-12 due to being found out of compliance with Conditions of Participation 42 CFR 484.10 Patient Rights; 42 CFR 484.12 Compliance with Federal, State, and Local Laws, Disclosure and Ownership Information, and Accepted Professional Standards and Principles; 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 418.18 Acceptance of Patients, Plans of Care, and Medical Supervision; 42 CFR 484.20 Reporting OASIS Information; 42 CFR 484.30 Skilled Nursing Services; 42 CFR</p>	G0000		

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

TITLE

(X6) DATE

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

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	<p>484.36 Home Health Aide Services; 42 CFR 484.48 Clinical Records; 42 CFR 484.52 Evaluation of the Agency's Program and 42 CFR 484.55 Comprehensive Assessments of Patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>September 28, 2012</p>			

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G0100	Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure patients had been informed of their rights in 3 of 10 records reviewed creating the potential to affect all future new admissions to the agency (See G 101); by failing to ensure patients had been provided with a written notice of their rights in 3 of 10 records reviewed creating the potential to affect all future new admissions to the agency (See G 102); by failing to ensure patients had been advised of the disciplines that would furnish care and the proposed frequency of visits in 3 of 10 records reviewed creating the potential to affect all future admissions to the agency (See G 108); by failing to ensure patients had been advised of the right to participate in planning care in 3 of 10 records reviewed creating the potential to affect all future admissions to the agency (See G 109); by failing to ensure patients had been provided with written information regarding advance directives in 3 of 10 records reviewed creating the potential to affect all future admissions to the agency (See G 110); by failing to ensure confidential clinical record information was maintained in a safe manner to	G0100	G0100 The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of their rights, by providing patients with a written notice of their rights, advising patients of the disciplines that would furnish care and the proposed frequency of visits, advising patients of the right to participate in planning care, provide patients with written information regarding advance directives, informing patients of payment expectations from the payer source, informing patients of the State home health hotline, in all of the agency's future admissions and ensuring that confidential clinical record information are maintained in a safe manner to protect patient confidentiality. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log to record the completeness of the admission packet before admission, and post admission, check that all documents have been signed by the patient or legal representative indicating that the patient has been informed of their rights, have been provided with a written notice of their rights, advised of the disciplines that would furnish	10/08/2012			

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	<p>protect patient confidentiality in 10 of 10 records reviewed creating the potential to affect all of the agency's 12 current patients (See G 111); by failing to ensure patients had been informed of payment expectations from the payer source and the patient in 3 of 10 records reviewed creating the potential to affect all future admissions to the agency (See G 113 and G 114); and by failing to ensure patients had been informed of the State home health hotline number in 3 of 10 records reviewed creating the potential to affect all of the agency's future admissions (See G 116).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.10 Patient Rights.</p>		<p>care and the proposed frequency of visits, advised of the right to participate in planning care, been provided with written information regarding advance directives, informed of payment expectations from the payer source, informed of the State home health hotline, and maintain these and all confidential clinical record information in a safe manner to protect patient confidentiality. 60% of admission records will be audited quarterly for evidence that patients have been informed of their rights, have been provided with a written notice of their rights, advised of the disciplines that would furnish care and the proposed frequency of visits, advised of the right to participate in planning care, been provided with written information regarding advance directives, informed of payment expectations from the payer source, informed of the State home health hotline, and that these and all confidential clinical record information have been maintained in a safe manner to protect patient confidentiality The Supervising registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The deficiency will be corrected by 10/08/2012</p>		

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G0101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of their rights in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future new admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights. A home visit was made to patient number 3 on 9-19-12 at 12:40 PM. The patient was unable to locate a home folder provided by the agency that would include a copy of the patient rights. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had 	G0101	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of their rights in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future new admissions to the agency. The findings include: 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights. A home visit was made to patient number 3 on 9-19-12 at 12:40 PM. The patient was unable to locate a home folder provided by the agency that would include a copy of the patient rights. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights. 3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The</p>	10/08/2012			

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	<p>been provided with a written notice of patient rights.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client or the client's</p>		<p>record failed to evidence the patient had been provided with a written notice of patient rights. 4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated. On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above. 5. The agency's undated "Client Rights" policy states, "The client or the client's family or guardian has the right to be informed of the client's rights through effective means of communication."The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of their rights, by providing patients with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment and</p>		

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	family or guardian has the right to be informed of the client's rights through effective means of communication."		documenting it. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the written notice of the client's rights in the admission packet, and post admission, check for documentation that the patient has been informed of their rights, and has been provided with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment. 60% of admission records will be audted quarterly for evidence that patients have been informed of their rights, and have been provided with a written notice of their rights. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	

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G0102	<p>484.10(a)(1) NOTICE OF RIGHTS</p> <p>The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of their rights in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future new admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights. <p>A home visit was made to patient number 3 on 9-19-12 at 12:40 PM. The patient was unable to locate a home folder provided by the agency that would include a copy of the patient rights.</p> <ol style="list-style-type: none"> 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had 	G0102	<p>G0102 The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of their rights, by providing patients with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment and documenting it. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the written notice of the client's rights in the admission packet, and post admission, check for documentation that the patient has been informed of their rights, and has been provided with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment. 60% of admission records will be audted quarterly for evidence that patients have been informed of</p>	10/08/2012	

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	<p>been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>		<p>their rights, and have been provided with a written notice of their rights. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur. The deficiency will be corrected by 10/08/2012</p>				

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	5. The agency's undated "Client Rights" policy states, "The client or the client's family or guardian has the right to be informed of the client's rights through effective means of communication. The home health agency shall provide the client with a written notice of the client's rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment and this shall be documented."			

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G0108	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been advised of the disciplines that would furnish care and the proposed frequency of visits in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge 	G0108	G0108 The Supervising Registered Nurse has in-serviced all Registered Nurses on advising the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished and documenting it. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the notice of the disciplines that will furnish care, and the frequency of visits proposed to be furnished in the admission packet. Post admission, the Supervising Registered Nurse will ensure that patients have been advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished	10/08/2012	

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	<p>date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable</p>		<p>and documented. 60% of admission records will be audited quarterly for three quarters for evidence that patients have been advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished and documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The agency shall advice [sic] the client in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."</p>			

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G0109	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE 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 clinical record and agency policy review and interview, the agency failed to ensure patients had been advised of the right to participate in planning care in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care. 	G0109	G0109The Supervising Registered Nurse has in serviced all Registered Nurses on advising the client in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log to record the inclusion of the "Patien's Rights" document in the admission packet, and post admission, check that all documents have been signed by the patient or legal representative indicating that the patient has been advised in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment. 60% of admission records will be audted quarterly for evidence that patients have been advised in advance of the right to participate in planning the care or treatment and in planning changes in the care or	10/10/2012			

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	<p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client has the right to participate in the planning of the care. The agency shall advise the client in</p>		<p>treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>		

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	advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment."			

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G0110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been provided with written information regarding advance directives in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives.</p>	G0110	G 0110The Supervising Registered Nurse has in-serviced all Registered Nurses on in advance of care of verbally advising and providing written information to all clients or client's legal representative of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state and documenting it.The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising	10/10/2012			

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	<p>2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable</p>		<p>Registered Nurse will ensure the inclusion of the information on advance directives in the admission packet. Post admission, the Supervising Registered Nurse will ensure that patients or their legal representatives have been verbally advised and provided written information of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state in advance of care and document it. 60% of admission records will be audited quarterly for three quarters for evidence that that patients or their legal representatives have been in advance of care, verbally advised and provided written information of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state and it is documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The agency shall inform and distribute written information to the client, in advance, concerning its policies on advance directives, including a description of applicable State law. The agency shall furnish advanced directives information to a client at the time of the first home visit before care is provided."</p> <p>6. The agency's undated "Advance Medical Directive" policy states, "At the time of the initial assessment of client eligibility for service or during the initial visit before care is furnished, the Agency shall: Verbally advise and provide written information to all clients or client's legal representative of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state."</p>			

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G0111	<p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure confidential clinical record information was maintained in a safe manner to protect patient confidentiality in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Upon arrival at the agency, on 9-18-12 at 9:00 AM, observation noted multiple stacks of clinical record information (physician orders, visit notes, plans of care, progress notes) in the front office of the agency on the desk, on the floor, in boxes, and on a round table in the middle of the small office. 2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the 	G0111	G 0111The Administrator has inserviced all healthcare personnel and clerical staff on ensuring that information is assembled and filed in a timely manner and systematic order in accordance with law and regulation to assure timely location and information retrieval. As well as ensuring that all client information is protected to reduce the risk of intentional or accidental misuse or loss of confidential information. Clerical staff will discontinue the practice of late filing and return to timely and systematic filing 60% of all clinical records will be audted quarterly for evidence that information was assembled and filed in a timely manner and systematic order in accordance with law and regulation, and that all client information was protected to reduce the risk of intentional or accidental misuse or loss of confidential information. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/18/2012			

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	<p>situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>3. A request was made to the administrator, employee I, for clinical records numbered 1, 5, and 9 on 9-18-12 at 10:00 AM. The administrator provided the records to the surveyor at 10:45 AM. The administrator was observed to sort through the multiple stacks of paper in the front office to try and retrieve portions of the clinical records that had been requested. The administrator stated, "I am trying to put the charts back together."</p> <p>4. On 9-18-12 at 1:55 PM, a request was made to the administrator, employee I, for records numbered 7 and 8 (both closed records). These records were not provided.</p> <p>4. Upon arrival at the agency, on 9-19-12 at 1:30 PM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>A. At 1:40 PM, records numbered 7 and 8 (closed records) were again requested from the administrator. Record number 7 was received and the</p>			

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	<p>administrator stated, "I'm still working on [getting record number 8]."</p> <p>B. At 2:20 PM, another request for record number 8 was made to the administrator, employee I.</p> <p>C. Record number 8 was reviewed on 9-19-12 at 3:05 PM. The record failed to include a discharge assessment. The administrator stated, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>5. Upon arrival to the agency, on 9-20-12 at 8:50 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>At 11:00 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>6. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the</p>				

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	<p>assessment process . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval."</p> <p>7. The agency's undated "Confidentiality and Client Information Security" policy states, "All client information will be protected to reduce the risk of intentional of accidental misuse or loss of confidential information."</p>			

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G0113	<p>484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.</p> <p>Based on clinical record review and interview, the agency failed to ensure patients had been informed of payment expectations from the payer source and the patient in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency,</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with information regarding expectations of payment from the payer source and the patient. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been provided with information regarding 	G0113	G0113The Supervising Registered Nurse has in-serviced all Registered Nurses on ensuring that patients or their legal representatives are informed of payment expectations from the payer source and the patient and document it.The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the information on payment expectations from the payer source and the patient in the admission packet. Post admission, the Supervising Registered Nurse will ensure that patients or their legal representatives have been informed of payment expectations from the payer source and the patient and documented it. 60% of admission records will be audited quarterly for three quarters for evidence that that patients or their legal representatives have been informed of payment expectations from the payer source and the	10/10/2012	

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	<p>expectations of payment from the payer source and the patient.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with information regarding expectations of payment from the payer source and the patient.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>		<p>patient and that it is documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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G0114	<p>484.10(e)(1(i-iii)) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of:</p> <p>(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;</p> <p>(ii) The charges for services that will not be covered by Medicare; and</p> <p>(iii) The charges that the individual may have to pay.</p> <p>Based on clinical record review and interview, the agency failed to ensure patients had been informed of payment expectations from the payer source and the patient in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency,</p> <p>The findings include:</p> <p>1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with information regarding expectations of payment from the payer source and the patient.</p> <p>2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had</p>	G0114	G 0114The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of payment expectations from the payer source.The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log. pre admission, the Supervising Registered Nurse will ensure that the payment expectation document is included in the Admission packet and post admission, check that all documents have been signed by the patient or legal representative indicating that the patient has been informed of payment expectations from the payer source.60% of admission records will be audted quarterly for evidence that patients have been informed of payment expectations from the payer source. The Supervising Registered Nurse is responsible for monitoring these	10/10/2012	

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	<p>been provided 1 time per week. The record failed to evidence the patient had been provided with information regarding expectations of payment from the payer source and the patient.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with information regarding expectations of payment from the payer source and the patient.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation</p>		corrective actions to ensure that these deficiencies are corrected and will not recur. The deficiency will be corrected by 10/08/2012				

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	and/or information regarding the findings in the records referenced above.				

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G0116	<p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of the State home health hotline number in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all of the agency's future admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the State home health hotline number to place a complaint. 2. Clinical record number 8 evidenced a 	G0116	G 0116 The Supervising Registered Nurse has in-serviced all Registered Nurses on ensuring that patients or their legal representatives are informed of the State home health hotline in all of the agency's future admissions. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the information the State home health hotline in the admission packet Post admission, the Supervising Registered Nurse will ensure that patients or their legal representatives have been informed of the State home health hotline and that it is	10/10/2012			

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	<p>start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the State home health hotline number to place a complaint.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the State home health hotline number to place a complaint.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable</p>		<p>documented. 60% of admission records will be audited quarterly for three quarters for evidence that that patients or their legal representatives have been informed of the State home health hotline and that itis documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client has the right to place a complaint with the department regarding treatment or care furnished by the agency."</p>			

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G0117	<p>484.12 COMPLIANCE W/ FED, STATE, LOCAL LAWS</p> <p>Based on observation, interview, and review of agency policy, it was determined the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Centers for Disease Control "Standard Precautions" in 4 of 4 home visit observations creating the potential to affect all of the agency's 12 current patients. (See G 121).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to be in compliance with this condition, 42 CFR 484.12 Compliance with Federal, State, and Local Laws; Disclosure and Ownership Information; and Accepted Professional Standards and Principles.</p>	G0117	<p>G 0117The Supervising Registered Nurse has in-serviced all healthcare personnel on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. All healthcare personnel received copies of policies and procedures on Hand washing, Standard Precautions, Blood Borne Pathogens.All Healthcare personnel will attend a mandatory Skills Day on 10/11/2012 during which return demonstrations on hand Washing, Standard Precautions and other Infection control practices will be done by every healthcare personnel. Healthcare personnel will discontinue the practice of not providing services in accordance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions" and healthcare personnel will follow the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions" when providing care.The Supervising Registered Nurse will make one unannounced visit to to each healthcare personnel providing services by 10/15/2012 and each quarter there after for the next three quarters to ensure compliance with the agency's</p>	10/15/2012	

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			Infection control policies and procedures and the Centers for Disease Control "Standard Precautions."The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that thes deficiencies are corrected and will not recur	

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G0121	<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.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Centers for Disease Control "Standard Precautions" in 4 (#s 1, 2, 3, and 4) of 4 home visit observations creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions for All Health Care Workers" policy states, "Hand Washing - Hands must be washed before and after contact with each client . . . Gloves - Vinyl or latex medical gloves must be worn when . . . catheter care . . . handling of grossly contaminated linens . . . providing oral hygiene . . . Gloves will be changed between client contact. When gloves are removed, thorough handwashing is required . . . Contaminated waste shall be disposed of in a double-plastic bag and placed in the client's trash container."</p>	G0121	<p>G 0121The Supervising Registered Nurse has in-serviced all healthcare personnel on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. All healthcare personnel received copies of policies and procedures on Hand washing, Standard Precautions, Blood Borne Pathogens.All Healthcare personnel will attend a mandatory Skills Day on 10/11/2012 during which return demonstrations on hand Washing, Standard Precautions and other Infection control practices will be done by every healthcare personnel. Healthcare personnel will discontinue the practice of not providing services in accordance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions" and healthcare personnel will follow the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions" when providing care. The Supervising Registered Nurse will make one unannounced visit to to each</p>	10/15/2012	

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	<p>A. The agency's undated "OSHA Regulations / Infection Control / Exposure Control Plan" policy states, "The agency shall maintain polices and procedures for . . . infection control practices by employees which conform with OSHA regulations and currently accepted standards of care."</p> <p>B. The agency's undated "Bloodborne Pathogens" policy states, "Universal precautions will be maintained during the performance of Agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves."</p> <p>C. The agency's undated "Infection Control Program" policy states, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives: . . . To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and</p>		<p>healthcare personnel providing services by 10/15/2012 and each quarter there after for the next three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions." The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that thes deficiencies are corrected and will not recur</p>				

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	<p>transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was made to patient</p>			

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	<p>number 6 with employee A, a home health aide, on 9-19-12 at 7:55 AM. The aide was observed to don clean gloves without cleansing her hands and assist the patient into the shower. The aide removed her gloves and cleansed her hands and made the patient's bed while the patient bathed. The aide then retrieved 2 pairs of clean gloves and placed them in her pocket, touched the bathroom door knob, and then donned clean gloves from the pocket without cleansing her hands.</p> <p>4. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse (LPN). The patient was observed to be bed bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube were observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked the dressing on the tip of the penis at the foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's face, head, chest, and arms. The LPN</p>				

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	<p>then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand, and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p> <p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and applied a cream to the legs. The LPN removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN applied the the mask to the patient's face</p>			

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	<p>and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p> <p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed control and the siderails while re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the phone and spoke with the caller. After</p>			
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	<p>completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and , using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto the patient's bed. The LPN emptied the container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse her hands.</p>			

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	<p>5. A home visit was made to patient number 3 with employee E, a registered nurse (RN) on 9-19-12 at 12:40 PM. The RN was not observed to wash her hands upon entering the home and starting the visit. The RN took the patient's vital signs and completed an assessment.</p> <p>6. A home visit was made to patient number 5 with employee D, a home health aide, on 9-20-12 at 8:00 AM. The aide washed his hands and assisted the patient to undress and into the shower. Upon request from the patient, the aide washed his hands and donned clean gloves and washed the patient's back. The aide then removed his gloves and failed to cleanse his hands. When the patient had completed the bath, the aide assisted the patient to dry the back and legs. Without cleansing his hands, the aide donned a clean glove to his left hand and applied an over-the-counter pain relief cream to the patient's upper back, shoulders, and knees and applied a different cream to the patient's groin area.</p> <p>After application of the cream to the patient's groin area, the aide removed his glove and failed to cleanse his hands. He then assisted the patient to don an adult disposable brief. The aide removed his glove and failed to cleanse his hands. The</p>			

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	<p>patient completed oral care and ambulated to the bedroom where the aide assisted the patient to don a shirt. Without cleansing his hand, the aide donned a clean glove to the left hand and applied lotion to the patient's legs bilaterally. The aide removed the glove and, without cleansing his hand, assisted the patient to don a stockinet and brace. The aide then assisted the patient to finish dressing and handed the patient the oxygen tubing to re-apply.</p> <p>7. The observations made during home visits numbered 1, 2, and 3 were discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observations.</p>				

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G0122	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p> <p>Based on clinical and administrative record and agency policy review, personnel file review, and interview, it was determined the agency failed to be in compliance with this condition by failing to ensure the governing body had arranged for a group of professional personnel that included at least 1 physician and other health care professionals creating the potential to affect all of the agency's 12 current patients (See G 130); by failing to ensure the administrator had maintained complete and accurate administrative and clinical records creating the potential to affect all of the agency's 12 current patients (See G 133); by failing ensure the administrator had provided for annual performance evaluations in 3 of 3 files of individuals employed for greater than 1 year creating the potential to affect all of the agency's 12 current patients; (See G 134); by failing to ensure the alternate supervising nurse would be available during operating hours creating the potential to affect all of the agency's 12 current patients (See G 139); by failing to provide a written contract for the provision of physical therapy and speech language pathology services creating the potential to affect all of the agency's 12</p>	G0122	<p>G0122 The agency has ensured that the governing body has arranged for a group of professional personnel that included at least 1 physician a registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers. The agency has put measures in place to ensure that the Administrator maintains complete and accurate administrative and clinical records, provide for annual performance evaluations, ensure the alternate supervising nurse would be available during operating hours, that the Administrator provide a written contract for the provision of physical therapy and speech language pathology services. ensure written summary reports had been sent to the attending physicians at least every 60 days for patients on service for longer than 60 days The Administrator will check by 10/15/2012 and yearly thereafter to ensure that the Governing Body has arranged for a group of professional personnel that are members of the Advisory Committee that meet the stipulations in the Organization's Guidelines policy on Advisory committee. 60% of clinical recrds</p>	10/15/2012			

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	<p>current patients if physical or speech therapy was needed (See G 142); and by failing to ensure written summary reports had been sent to the attending physicians at least every 60 days in 9 of 9 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients (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>will be audited for completeness and accuracy. 100% of employees files will be audited for evidence of completion of annual performance evaluations for employees that have been employed for over one year. The Administrator will check quarterly for three quartreto ensure that the alternate supervising nurse would be available during operating hoursThe Administrator will check quarterly for three quartreto ensure that a written contract for the provision of physical therapy and speech language pathology services is available and accessible60% of clinical recrds will be audited to ensure that written summary reports have been sent to the attending physicians at least every 60 days for patients on service for longer than 60 days The Administrator will be responsible for monitoring these correccive actions to ensure that this deficiency is corrected and will not recur</p>	

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G0130	<p>484.14(b) GOVERNING BODY The governing body arranges for professional advice as required under §484.16. Based on administrative record and agency policy review and interview, the governing body failed to arrange for a group of professional personnel that included at least 1 physician and other health care professionals creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records included "Advisory Committee Meeting" minutes dated 2-14-12. The meeting minutes evidenced 2 registered nurses and a community member was present at the meeting. The minutes failed to evidence a physician or any other health professional was in attendance at the meeting. 2. The administrator was unable to provide any additional documentation and/or information regarding the professional group advisory meetings when asked on 9-20-12 at 11:10 AM and 12:50 PM. 3. The agency's undated "Organizational Guidelines" policy states, "Advisory 	G0130	G0130The Governing Board has arranged for the Advisory Committee to be reconstituted to include a physician, a registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers. All information and or documentation regarding the Advisory Committee have been set up by the Administrator to be filed and made easily accessible.The Administrator will check by 10/15/2012 and yearly thereafter to ensure that the Governing Body has arranged for a group of professional personnel that are members of the Advisory Committee that meet the stipulations in the Organization's Guidelines policy on Advisory committee.The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	10/15/2012			

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	Committee: The Board of Directors shall designate a group of professional personnel . . . The Advisory Committee shall consist of at least one (1) physician; one (1) registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers."			

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G0133	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on interview, the administrator failed to ensure complete and accurate administrative and clinical records had been maintained creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The administrator, employee I, was unable to provide documentation and/or any additional information regarding the completion of annual performance evaluations when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM. 2. The administrator failed to provide for review contracts for the provision of physical therapy and speech language pathology services when asked on 9-19-12 at 3:20 PM and on 9-20-12 at 11:10 AM and 12:50 PM. 3. The administrator was unable to provide complete clinical records for review. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need 	G0133	G 0133The Administrator has reviewed the agency's policy on annual performance evaluations, contracts, clinical records, home health aide competency evaluations, clinical record reviews, OASIS data transmission, quality assessment and performance improvement program. The Agency has put in place a policy for the evaluation of the agency's total program,100% of employee files will be audited quarterly for four quarters to ensure that annual evaluations have been performed on employees that have been employed greater than one year. 100% of all contract files will be audited quarterly for four quarters to ensure that there are contracts for all services provided by contracted providers and are accessible for review60% of all clinical records will be audited for three quarters for evidence that of maintenance of complete records.100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency completed a competency	10/12/2012			

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	<p>to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated. On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in records 1 through 10.</p> <p>4. The administrator was unable to provide documentation and/or additional information regarding the completion of home health aide competency evaluations when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>5. The administrator was unable to provide any policies and procedures that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>6. The administrator was unable to provide any documentation any clinical record reviews had been completed when</p>		<p>evaluation program, and that documentation is maintained in their file to confirm the completion of the program. The administrator will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60 day period that a patient receives home care, 100% of OASIS data collected will be audited to ensure that they were transmitted within 30 days of completing an assessment and at least monthly for patients that receive skilled services. The agency's Policy Manual now includes a policy on an evaluation of the agency's total program and the agency's quality assessment and performance improvement program will be monitored quarterly to ensure that it is being performed.. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>7. The administrator indicated, on 9-18-12 at 9:00 AM, the agency had experienced some difficulties with OASIS data transmission and that the problems were due to a "software" problem but was unable to provide any documentation and/or additional information that the problems had been addressed.</p> <p>8. The administrator was unable to provide any documentation and/or information that the agency's quality assessment and performance improvement program had been completed per the agency's own policy. when asked on 9-20-12 at 1:25 PM and 1:45 PM.</p>			

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G0134	<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, employs qualified personnel and ensures adequate staff education and evaluations. Based on personnel file and agency policy review and interview, the administrator failed to ensure annual performance evaluations had been completed in 3 (files C, E, and F) of 3 files of individuals employed for greater than 1 year creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed. 2. Personnel file E evidenced the individual had been hired on 2-21-06 to provided skilled nursing on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009. 3. Personnel file F evidenced the individual had been hired on 4-24-03 to provide occupational therapy services on 	G0134	<p>G 0134The administrator has reviewed and inserviced on the agency's policy on annual performance evaluations and has set up onsite supervisory visits with each professional staff member, including contract staff, as scheduling allows to evaluate performance, client care, coordination of services, organization and time management, documentation and other aspects of performance as indicated. 100% of employee files will be audited quarterly for four quarters to ensure that annual evaluations have been performed on employees that have been employed greater than one year. The Supervising Registered Nurse will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur</p>	10/12/2012

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	<p>behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.</p> <p>5. The agency's undated "Supervision and Evaluation of Staff" policy states, "As scheduling allows, the supervisor will make an onsite supervisory visit with each professional staff member, including contract staff, no less often than annually to evaluate performance, client care, coordination of services, organization and time management, documentation and other aspects of performance as indicated . . . As scheduling allows, the supervisor will make or arrange for onsite supervisory visits with each therapist no less often than annually."</p>			

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G0139	<p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE</p> <p>Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure the alternate supervising nurse would be available during operating hours creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the entrance conference, on 9-18-12 at 9:00 AM, the administrator, employee I, indicated she also functions as the agency's supervising nurse and that employee G is the agency's alternate administrator and alternate supervising nurse. 2. The agency's administrative records included an undated "Designation of An Alternate" document that states, "In the absence of the supervising nurse, the authority for the management of clinical services shall be assigned to: [employee 	G0139	G 0139The administrator has reviewed and inserviced on the agency's policy on Client Acceptance / Staff Assignment policy. The agency has designated a qualified alternate Supervising Registered Nurse who is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency and is in the process of completing the application. The Supervising Registered Nurse will ensure that the designated alternate is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency. The Supervising Registered Nurse will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur	10/16/2012	

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	<p>G]."</p> <p>3. On 9-20-12 at 9:30 AM, the administrator, employee I, indicated the alternate supervising nurse, employee G, lives in Dallas, Texas, and would not be physically available in the agency if needed in an emergency. The administrator stated, "I know. I plan to make [employee E] the alternate administrator and alternate supervising nurse."</p> <p>4. The agency's undated "Client Acceptance / Staff Assignment" policy states, "The supervising registered nurse or a designated qualified alternate is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency."</p>				

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G0142	<p>484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT</p> <p>If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following:</p> <p>(1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.</p> <p>Based on agency policy review and and interview, the agency failed to provide a written contract for the provision of physical therapy and speech language pathology services creating the potential to affect all of the agency's 12 current patients if physical or speech therapy was needed.</p> <p>The findings include:</p> <p>1. During the entrance conference, on 9-18-12 at 9:00 AM, the administrator, employee I, indicated physical therapy services were provided by employees of</p>	G0142	G 0142The administrator has reviewed and inserviced on the agency's policy on Evaluation of Services and Scope of Care. The Administrator will ensure that all contracts are accessible and available for review. 100% of all contract files will be audited quarterly for four quarters to ensure that there are contracts for all services provided by contracted providers and are accessible for review.The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	10/10/2012			

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	<p>the agency and by a contracted provider. The administrator indicated speech language pathology services were provided by a contracted provider.</p> <p>2. The administrator, employee I, failed to provide for review contracts for the provision of physical therapy and speech language pathology services when asked on 9-19-12 at 3:20 PM and on 9-20-12 at 11:10 AM and 12:50 PM.</p> <p>3. The agency's undated "Evaluation of Services and Scope of Care" policy states, "If personnel under contract are used by the agency or services are furnished under arrangements, there shall be a written contract between those personnel or service provider and the agency."</p>				

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G0145	<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 clinical record and agency policy review and interview, the agency failed to ensure written summary reports had been sent to the attending physicians at least every 60 days in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced the agency had provided home health aide services 1 time per week during the certification periods 11-22-11 to 1-20-12, 1-21-12 to 3-20-12, 5-20-12 to 7-18-12, and 7-19-12 to 9-16-12. The record failed to evidence any written summary reports had been sent to the physician for these certification periods. 2. Clinical record number 2 evidenced the agency had provided skilled nursing (SN) services 4 to 5 times per week during the certification periods 2-6-12 to 4-5-12, 4-6-12 to 6-4-12, 6-5-12 to 8-3-12, and 8-4-12 to 10-2-12. The record failed to evidence any written summary reports had been sent to the 	G0145	G 0145The Supervising Registered Nurse has in-serviced nursing staff that a written summary report regarding the client's progress is prepared by the case manager for all applicable disciplines participating in the client's care and is submitted to the physician at least every 60 days and a copy of the summary is maintained in the clinical record.60% of all clinical records will be audited quarterly for three quarters for evidence that a written summary report for each patient was sent to the attending physician every 60 days.The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that to ensure that this deficiency is corrected and will not recur.	10/10/2012			

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	<p>physician.</p> <p>3. Clinical record number 3 evidenced the agency had provided SN and attendant care (ATTC) services 1 time per week during the certification periods 5-22-12 to 7-20-12 and 7-21-12 to 9-18-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>4. Clinical record number 4 evidenced the agency had provided home health aide services 3 times per week during the certification periods 3-10-12 to 5-8-12, 5-9-12 to 7-7-12, and 7-8-12 to 9-5-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>5. Clinical record number 5 evidenced the agency had provided SN 1 time per week and home health aide services 5 times per week during the certification periods 5-7-12 to 7-5-12, 7-6-12 to 9-3-12, and 9-4-12 to 11-2-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>6. Clinical record number 6 evidenced the agency had provided home health aide services 1 to 2 times per day 5 days per week during the certification periods</p>			

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	<p>2-11-12 to 4-10-12, 4-11-12 to 6-9-12, 6-10-12 to 8-8-12, and 8-9-12 to 10-7-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>7. Clinical record number 7 evidenced the agency had provided SN services 3 times per week and physical therapy (PT) services 1 to 2 times per week during the certification period 6-24-12 to 8-22-12 and 8-23-12 to 10-12-12 with a discharge date of 9-6-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>8. Clinical record number 9 evidenced the agency had provided SN services 1 to 2 times per week during the certification periods 12-5-11 to 2-4-12, 2-2-12 to 4-5-12, 4-2-12 to 5-31-12, 6-1-12 to 7-31-12, and 8-1-12 to 9-28-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>9. Clinical record number 10 evidenced the agency had provided SN services 1 time per week during the certification periods 4-4-12 to 6-2-12, 6-3-12 to 8-1-12, and 8-2-12 to 9-30-12. The record failed to evidence any written summary reports had been sent to the physician.</p>				

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	<p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>11. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy states, "At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of treatment for review by the physician. The recertification of physician's order's summary shall include: Changes in client's physical or psychosocial condition, The client's</p>						

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	<p>response to care/services, The client's outcome to care/services."</p> <p>12. The agency's undated "Summary Report" policy states, "A summary report regarding the client's progress is prepared by the case manager for all applicable discipline participating in the client's care and is submitted to the physician at least every 60 days. A copy of the summary is maintained in the clinical record."</p>			

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G0151	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure a group of professional personnel had reviewed the agency's policies as required creating the potential to affect all of the agency's 12 current patients (See G 152 and G 153) and by failing to ensure a group of professional personnel had met frequently to advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community creating the potential to affect all of the agency's 12 current patients (See G 154).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.16 Group of Professional Personnel.</p>	G0151	<p>G0151 The Administrator has reviewed and inserviced on the agency's policy on the group of professional personnel that review the agency's policies. The professional group will meet by 10/15/2012 and frequently thereafter to review the agency's policies and advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community and maintain documentation of such. The Administrator will check by 10/15/2012 and quarterly thereafter to ensure that the professional group has met to review the agency's policies and advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community and maintain documentation of such. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	10/15/2012	

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G0152	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel that included at least 1 physician and other health care professionals had been appointed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records included "Advisory Committee Meeting" minutes dated 2-14-12. The meeting minutes evidenced 2 registered nurses and a community member was present at the meeting. The minutes failed to evidence a physician or any other health professional were in attendance at the meeting. 2. The administrator, employee I, stated, on 9-20-12 at 12:50 PM, "The advisory committee is our professional advisory group. We meet one time per year. We did do a policy review but did not write it down." 	G0152	G0152The Administrator has inserviced and reviewed the agency's policy on Advisory Comitte. The agency is reconstituted the Advisory Committee to include a physician, a registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers. The Administrator will check by 10/15/2012 and quarterly thereafter to ensure that the Governing Body has arranged for a group of professional personnel that are members of the Advisory Committee that meet the stipulations in the Organization's Guidelines policy on Advisory committee. The Administrator will ensure that all members are in attendance at scheduled meetings. The Administrator will be responsible for monitoring these correcive actions to ensure that this deficiency is corrected and will not recur	10/15/2012			

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	<p>3. The administrator was unable to provide any additional documentation and/or information regarding the professional group advisory meetings when asked on 9-20-12 at 11:10 AM and 12:50 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Advisory Committee: The Board of Directors shall designate a group of professional personnel . . . The Advisory Committee shall consist of at least one (1) physician; one (1) registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers."</p>				

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G0153	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel had reviewed the agency's policies as required creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records included "Advisory Committee Meeting" minutes dated 2-14-12. The meeting minutes evidenced 2 registered nurses and a community member were present at the meeting. The minutes failed to evidence the required policies had been reviewed. 2. The administrator, employee I, stated, on 9-20-12 at 12:50 PM, "The advisory committee is our professional advisory group. We meet one time per year. We did do a policy review but did not write it 	G0153	G 0153 The Administrator has inserviced and reviewed the agency's policy on Advisory Comittee. The agency has reconstituted the Advisory Committee to include a physician, a registered professional nurse, and other medical professionals and lay persons knowledgeable in health affairs such as medical social workers, lawyers, therapist, pharmacists, and consumers. The Administrator will check by 10/15/2012 and quarterly thereafter to ensure that the Advisory Comittee has reviewed the Agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification, and program evaluation at least annually and are documented. The Administrator will ensure that all members are in attendance at scheduled meetings.The Administrator will be responsible	10/15/2012			

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	<p>down."</p> <p>3. The administrator was unable to provide any additional documentation and/or information regarding the professional advisory group meetings when asked on 9-20-12 at 11:10 AM and 12:50 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Advisory Committee: The Board of Directors shall designate a group of professional personnel . . . The Advisory Committee shall: Establish and annually review the Agency policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, and personnel qualification, and program evaluation."</p>		for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0154	<p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel had met frequently to advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records included "Advisory Committee Meeting" minutes dated 2-14-12. The meeting minutes evidenced 2 registered nurses and a community member was present at the meeting. The minutes failed to evidence any participation in an evaluation of the agency's total program, coordination and communication with other providers, or advisement on any professional issues. 2. The administrator, employee I, stated, on 9-20-12 at 12:50 PM, "The advisory committee is our professional advisory 	G0154	G 0154The Administrator has reviewed and inserviced on the agency's policy on the group of professional personnel that advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community. The professional group will meet by 10/15/2012 and frequently thereafter to review the agency's policies and advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community and maintain documentation of such. The Administrator will check by 10/15/2012 and quarterly thereafter to ensure that the professional group has met to review the agency's policies and advise on professional issues, participate in the agency evaluation, and coordinate with other providers in the community and maintain documentation of such. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	10/15/2012			

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	<p>group. We meet one time per year. We did do a policy review but did not write it down."</p> <p>3. The administrator was unable to provide any additional documentation and/or information regarding the professional advisory group meetings when asked on 9-20-12 at 11:10 AM and 12:50 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Advisory Committee: The Board of Directors shall designate a group of professional personnel . . . The Advisory Committee shall: Advise the Agency on professional issues, Participate in the annual evaluation of the Agency's program, Assist the Agency in maintaining liaison with other health care providers in the community and in its community information program."</p>				

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G0156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure compliance with this condition by failing to ensure home health aide and skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 8 of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients (See G 158); by failing to ensure plans of care that included all of the required items had been maintained in 8 of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients (See G 159); and by failing to ensure plans of care had been reviewed by the attending physician at least every 60 days in 8 of 8 active clinical records reviewed creating the potential to affect all of the agency's 12 current patients (See G 163).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 418.58 Acceptance of Patients, Plans of Care, and Medical Supervision.</p>	G0156	G 0156 The Supervising Registered Nurse has inserviced Registered Nurses and Home Health Aides on providing care to patients in accordance with a written plan of care established by the physician.. Registered Nurses were also inserviced on ensuring that the plans of care included all of the required items and that all plans of care are reviewed by the attending physician at least every 60 days. 60% of all clinical records will be audited monthly for three quarters to ensure that care is being provided in accordance with a written care plan established by the attending physician, that the plans of care include all of the required items and that all plans of care are reviewed by the attending physician at least every 60 days. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure home health aide and skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Patient number 1 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 4-07-09. Clinical record number 1 failed to evidence plans of care signed by the physician for home health aide services provided after 01-20-12.</p> <p>B. Patient number 2 was included on the list of current patients. The list</p>	G0158	The Supervising Registered Nurse has inserviced Registered Nurses on ensuring plans of care are developed within 7 days of the assessment and shall be signed and dated by the physician and that all plans of care are reviewed by the attending physician at least every 60 days. 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care are developed within 7 days of the assessment and shall be signed and dated by the physician and that all plans of care are reviewed by the attending physician at least every 60 days. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>C. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p>						

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	<p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Patient number 4 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 3-16-11. Clinical record number 4 failed to evidence a plan of care signed by the physician for the certification period 9-6-12 to 11-4-12.</p> <p>The record included home health aide visit notes that evidenced home health aide services had been provided 3 times per week during the certification period.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with</p>						

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	<p>employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence a plan of care signed by the physician for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p> <p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p> <p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p>				

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	<p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any</p>				

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	<p>additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Medical Supervision" policy states, "The physician, dentist, chiropractor, podiatrist or optometrist will provide complete and accurate information about the client and shall sign and date a written medical plan of care and subsequent change orders."</p> <p>The agency's undated "Physician's Plan of Treatment (Care) / Change Orders" policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated by the attending physician . . . The Agency will provide care/services consistent with the plan of care."</p>				

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G0159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure clinical records contained plans of care that included all of the required items in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM. <ul style="list-style-type: none"> A. Patient number 1 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 4-07-09. Clinical record number 1 failed to evidence plans of care signed by the physician for home health aide 	G0159	G 0159The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that plans of care include all required items including: 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. 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care include all required items The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>services provided after 01-20-12.</p> <p>B. Patient number 2 was included on the list of current patients. The list evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>C. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p>						

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	<p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Patient number 4 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 3-16-11. Clinical record number 4 failed to evidence a plan of care signed by the physician for the certification period 9-6-12 to 11-4-12.</p> <p>The record included home health aide visit notes that evidenced home health aide services had been provided 3 times per week during the certification period.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the</p>						

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	<p>certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence a plan of care signed by the physician for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p> <p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p> <p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of</p>				

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	<p>12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was</p>			

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	<p>terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Physician's Plan of Treatment (Care) / Change Orders" policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated by the attending physician . . . The plan of care shall include but not be limited to: Date plan was established, Diagnosis-primary and secondary, Specific discipline, frequency and duration of services, Functional limitations; safety precautions, Mental status, Homebound status, Prognosis, Medications, allergies, Diet, Medical supplies and equipment, Activity permitted and restricted, Orders for treatment, treatment modalities, laboratory tests, Goals, Discharge plans, including rehabilitation potential and anticipated length of service delivery."</p>				

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G0163	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure plans of care had been reviewed by the physician at least every 60 days in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Clinical record number 1 included a plan of care for the certification period 11-22-11 to 01-20-12 that had been signed by the physician on 12-22-11 The record failed to evidence any plans of care</p>	G0163	G0163 The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that plans of care have been reviewed by the physician atleast every 60 days 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care been reviewed by the physician at least every 60 days The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>had been reviewed by the physician since 12-22-11. The agency's list of current patients evidenced patient number 1 is currently receiving home health aide services.</p> <p>B. Clinical record number 2 included a plan of care for the certification period 6-5-12 to 8-3-12 and signed by the physician on 6-10-12. The record failed to evidence the physician had reviewed a plan of care since 6-10-12. The agency's list of current patients evidenced patient number 2 is currently receiving skilled nurse (SN) services.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period 8-4-12 to 10-2-12.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>C. Clinical record number 3 included a plan of care for the certification period 5-22-12 to 7-20-12 that had been signed</p>			

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	<p>by the physician on an unknown date. The record failed to evidence the physician had completed any further review of a plan of care. The agency's list of current patients evidenced patient number 3 is currently receiving SN and homemaker services.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period 07-21-12 to 09-18-12.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Clinical record number 4 included a plan of care for the certification period 7-8-12 to 9-5-12 that had been signed by the physician on 7-30-12 and that evidenced the agency was to provide home health aide services 3 times per week.</p> <p>1.) The record failed to evidence the physician had reviewed a plan of care for the next certification period, 9-6-12 to 11-4-12.</p> <p>2.) The record evidenced home</p>			

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	<p>health aide services had been provided 3 times per week during the certification period 9-6-12 to 11-4-12.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence the physician had reviewed a plan of care for the certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence the physician had reviewed a plan of care for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p>			

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	<p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p> <p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence the physician had reviewed any plans of care for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence the physician had reviewed a plan of care for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p>			

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NAME OF PROVIDER OR SUPPLIER HEALTHSET			STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714		
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	<p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Physician's Plan of Treatment (Care) /Change Orders" policy states, "The Agency will provide care/services consistent with the plan of care. The plan shall be reviewed by the attending physician in consultation with the Agency's professional staff at such intervals as the client's condition requires but at least every 60 days."</p>				

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G0168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure compliance with this condition by failing to ensure skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 5 of 5 records of patients that received skilled nursing services creating the potential to affect all of the agency's 5 current patients that received skilled nursing services (See G 170); by failing to ensure the registered nurse had made an initial assessment visit in 3 of 10 records reviewed creating the potential to affect all of the agency's new patients (See G 171); by failing to ensure the registered nurse had updated comprehensive assessments and re-evaluated the patients' nursing needs at every 60 days in 9 of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients (See G 172); by failing to ensure the licensed practical nurse (LPN) had provided services in accordance with the agency's infection control policies and procedures in 1 of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and all of the agency's 12 current patients</p>	G0168	<p>G 0168The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that care provided is according to a written plan of care established by the physician, initial assessments are made by the Registered Nurse, and updated and re-evaluation of the patient's nursing needs are performed by the Registered nurse every 60 days. The Registered Nurses and LPN were inserviced on providing services in accordance with the agency's infection control policies and procedures, 60% of all clinical records will be audited monthly for three quarters to ensure that care provided is according to a written plan of care established by the physician, initial assessments are made by the Registered Nurse, and updated and re-evaluation of the patient's nursing needs are performed by the Registered nurse every 60 days, that services are provided services in accordance with the agency's infection control policies and procedures, The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	10/12/2012			

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	<p>(See G 179); and the LPN failed to maintain aseptic technique while preparing equipment for a breathing treatment in 1 (employee B) of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and the agency's 12 current patients (See G 182).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to be in compliance with the Condition 42 CFR 484.30 Skilled Nursing Services.</p>			

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 5 (#s 2, 3, 5, 9, and 10) of 5 records of patients that received skilled nursing services creating the potential to affect all of the agency's 5 current patients that received skilled nursing services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM. <ul style="list-style-type: none"> A. Patient number 2 was included on the list of current patients. The list evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12. <ul style="list-style-type: none"> 1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period. 	G0170	G 0170 The Supervising Registered Nurse has inserved Registered Nurses on ensuring that care provided is according with a written plan of care established by a physician. 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care are signed and dated by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>B. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>C. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and</p>						

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	<p>home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the certification period 9-4-12 to 11-2-12.</p> <p>D. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>E. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2. The administrator, employee I, stated,</p>			

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Medical Supervision" policy states, "The physician, dentist, chiropractor, podiatrist or optometrist will provide complete and accurate information about the client and shall sign and date a written medical plan of care and subsequent change. orders."</p> <p>The agency's undated "Physician's Plan of Treatment (Care) / Change Orders" policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated</p>			

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	by the attending physician . . . The Agency will provide care/services consistent with the plan of care."			

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G0171	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence an initial assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence an initial assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence an initial assessment had been completed. 4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former 	G0171	G 0171 The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that initial assessment visits are completed and filed in the patient's chart. .60% of all clinical records will be audited monthly for three quarters to ensure that initial assessment visits have been completed and filed in the patient's chart. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012	

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	<p>employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from</p>						

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G0172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had updated comprehensive assessments and re-evaluated the patients' nursing needs at every 60 days in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 identified a start of care date of 4-7-09 and that the comprehensive assessment had been updated on 7-21-11 and 11-18-11 by the RN, employee E. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 11-18-11. 2. Clinical record number 2 identified a start of care date 2-6-12 and that a start of care comprehensive assessment had been completed on 2-6-12 by the RN, employee E. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs at 	G0172	<p>G0172The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that comprehensive assessments are updated and the patient's nursing needs every 60 days by the Registered Nurse and filed in the patient's chart. 60% of all clinical records will be audited monthly for three quarters to ensure that comprehensive assessments are updated and the patient's nursing needs every 60 days by the Registered Nurse and filed in the patient's chart. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	10/12/2012	

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	<p>any time after the start of care.</p> <p>3. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence any the RN had completed any comprehensive assessments to re-evaluate the patient's nursing needs.</p> <p>4. Clinical record number 4 identified a start of care date of 3-16-11 and that the RN, employee E, had updated the comprehensive assessment on 11-9-11. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 11-9-11.</p> <p>5. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence the RN had completed any comprehensive assessments to evaluate and re-evaluate the patient's nursing needs.</p> <p>6. Clinical record number 6 identified a start of care date of 12-15-10. The record evidenced the RN, employee E, had updated the comprehensive assessment on 4-11-11, 8-10-11, and 10-12-11. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 10-12-11.</p>						

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	<p>7. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced the RN, employee E, had updated the comprehensive assessment at discharge on 9-12-12. The record failed to evidence the RN had completed a comprehensive at start of care or at recertification to re-evaluate the patient's nursing needs.</p> <p>8. Clinical record number 9 identified a start of care date of 2-26-10 and that the RN, employee I, had updated the comprehensive assessment and re-evaluated the patient's nursing needs on 12-4-11, 2-1-12, and not again until 7-27-12.</p> <p>9. Clinical record number 10 identified a start of care of 8-8-11 and that RN, employee E, had updated the comprehensive assessment and re-evaluated the patient's nursing needs on 1-31-12. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 1-31-12.</p> <p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the</p>				

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	<p>administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>			

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G0179	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. Based on agency policy review, observation, and interview, the agency failed to ensure the licensed practical nurse (LPN) had provided services in accordance with the agency's infection control policies and procedures in 1 (employee B) of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions for All Health Care Workers" policy states, "Hand Washing - Hands must be washed before and after contact with each client . . . Gloves - Vinyl or latex medical gloves must be worn when . . . catheter care . . . handling of grossly contaminated linens . . . providing oral hygiene . . . Gloves will be changed between client contact. When gloves are removed, thorough handwashing is required . . . Contaminated waste shall be disposed of in a double-plastic bag and placed in the client's trash container."</p> <p>A. The agency's undated "OSHA Regulations/Infection Control/Exposure</p>	G0179	<p>G0179 The Supervising Registered Nurse has in-serviced the LPN on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. The LPN received copies of policies and procedures on Hand washing, Standard Precautions, Blood Borne Pathogens. the Supervising The LPN will attend a mandatory Skills Day on 10/11/2012 during which she will perform return demonstrations on hand Washing, Standard Precautions and other Infection control practices. The Supervising Registered Nurse will make weekly unannounced visits to the LPN for while providing services, then, monthly, and then, once a quarter for three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions." The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	10/12/2012			

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	<p>Control Plan" policy states, "The agency shall maintain polices and procedures for . . . infection control practices by employees which conform with OSHA regulations and currently accepted standards of care."</p> <p>B. The agency's undated "Bloodborne Pathogens" policy states, "Universal precautions will be maintained during the performance of Agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves."</p> <p>C. The agency's undated "Infection Control Program" policy states, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives: . . . To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p>			

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	<p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse</p>			

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	<p>(LPN). The patient was observed to bed bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube was observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked the dressing on the tip of the penis at the foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's face, head, chest, and arms. The LPN then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p> <p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually</p>			

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	<p>wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and applied a cream to the legs. The LPN removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN applied the the mask to the patient's face and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p>			

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	<p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed control and the siderails while re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the phone and spoke with the caller. After completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and , using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She</p>			

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	<p>then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto the patient's bed. The LPN empties the container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse her hands.</p> <p>4. The observation made the during home visit with patient #2 was discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observation.</p>				

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G0182	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required.</p> <p>Based on observation and interview, the licensed practical nurse (LPN) failed to maintain aseptic technique while preparing equipment for a breathing treatment in 1 (employee B) of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse (LPN). The patient was observed to be bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube was observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked the dressing on the tip of the penis at the</p>	G0182	G0182 The Supervising Registered Nurse has in-serviced the LPN on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. The LPN received a copy of policies and procedures on Aseptic technique, Standard Precautions, and Blood Borne Pathogens. The LPN will attend a mandatory Skills Day on 10/11/2012 during which she will perform return demonstrations on hand Washing, Standard Precautions and aseptic technique The Supervising Registered Nurse will make weekly unannounced visits to the LPN for two weeks while providing services, then, monthly, and then, once a quarter for three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/11/2012			

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	<p>foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's face, head, chest, and arms. The LPN then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p> <p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and applied a cream to the legs. The LPN</p>			

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	<p>removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN applied the the mask to the patient's face and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p> <p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed control and the siderails while</p>				

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	<p>re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the phone and spoke with the caller. After completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and , using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto the patient's bed. The LPN empties the</p>			

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	<p>container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse her hands.</p> <p>2. The observation made the during home visit with patient #2 was discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observation.</p>			

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to ensure compliance with this condition by failing to ensure home health aides that provided services on behalf of the agency met the personnel qualification requirements at 42 CFR 484.4 in 2 of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 203); by failing to ensure home health aides that provided services on behalf of the agency had completed a competency evaluation program in 2 of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 211); by failing to ensure home health aides completed a competency evaluation that addressed all of the required subject areas in 2 of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 213); by failing to ensure a performance review had been completed at least every 12 months in 1 of 1 home aide file reviewed of aides that had been employed for greater than 12 months creating the potential to affect all of the agency's 8 current patients that</p>	G0202	<p>G 0202 The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency meet the personnel qualification requirements, that home health aides that provide services on behalf of the agency have completed a competency evaluation program, that home health aides complete a competency evaluation that addresses all of the required subject areas, that home health aides that provide services on behalf of the agency had been found competent in accordance with 484.36(b) The Administrator, has inserviced Registered nurses to ensure that the registered nurse has completed home health aide assignments, that the registered nurse (RN) has performed supervisory visits at least every two (2) weeks according to the agency's own policy The Administrator has inserviced on and reviewed agency policies to ensure that a performance review is completed at least every 12 months for aides that have been employed for greater than 12 months, to maintain documentation that home health aides that provided services on behalf of the agency meet the personnel qualification requirements 100% of Home</p>	10/12/2012	

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	receive home health aide services (See G 214); by failing to maintain documentation that home health aides that provided services on behalf of the agency met the personnel qualification requirements at 42 CFR 484.4 and met the competency evaluation requirements of this section in 2 of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 221); by failing to ensure home health aides that provided services on behalf of the agency had been found competent in accordance with 484.36(b) in 2 of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 222); by failing to ensure the registered nurse had completed home health aide assignments in 5 of 5 records reviewed of patient that received home health aide services creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 223); by failing to ensure the registered nurse had completed home health aide assignments in 5 of 5 records reviewed of patient that received home health aide services creating the potential to affect all of the agency's 8 current patients that receive home health aide services (See G 224); and by failing to ensure the registered		health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency meet the personnel qualification requirements, that home health aides that provide services on behalf of the agency have completed a competency evaluation program, that home health aides complete a competency evaluation that addresses all of the required subject areas, that home health aides that provide services on behalf of the agency had been found competent in accordance with 484.36(b) and documentation is maintained that home health aides that provided services on behalf of the agency meet the personnel qualification requirements that a performance review is completed at least every 12 months for aides that have been employed for greater than 12 months60% of clinical records will be audited mothly for three months to ensure that the registered nurse has completed home health aide assignments, and that the registered nurse (RN) has performed supervisory visits at least every two (2) weeks according to the agency's own policy. The Administrator will be responsible for monitoring these correcrive actions to ensure that this deficiency is corrected and will not recur. .				

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	<p>nurse (RN) had performed supervisory visits at least every two (2) weeks per the agency's own policy in 5 of 5 records of patients that received home health aide services creating the potential to affect the agency's 2 current patients that receive home health aide and SN services (See G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.36 Home Health Aide Services</p>			

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G0203	<p>484.36(a) HOME HEALTH AIDE SERVICES Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in §484.4 for "home health aide".</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides that provided services on behalf of the agency met the personnel qualification requirements at 42 CFR 484.4 in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 2. Personnel file D evidenced the 	G0203	G0203The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency meet the personnel qualification requirement in 42 CFR 484.2 and must have completed the competency evaluation program utilizing a written examination and a competency skills test and documentation maintained of completion of the program. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency meet the personnel qualification requirement in 42 CFR 484.2 and must have completed the competency evaluation program utilizing a written examination and a competency skills test and documentation maintained of completion of the program. The	10/12/2012			

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	<p>individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program.</p> <p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health / personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>		Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides that provided services on behalf of the agency had completed a competency evaluation program in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 2. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 	G0211	<p>G 0211 The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency agency must have completed the competency evaluation program utilizing a written examination and a competency skills test and documentation maintained of completion of the program. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency completed a competency evaluation program, and that documentation is maintained in their file to confirm the completion of the program. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	10/12/2012	

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	<p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health / personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>			

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G0213	<p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides completed a competency evaluation that addressed all of the required subject areas in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program that addressed any of the required subject areas. 2. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program that addressed 484.36(a)(1)(ix)(A) bed bath. 	G0213	G 0213The Administrator, has inserviced contractors on ensuring that Home health aides that home health aides complete a competency evaluation that addresses all of the required subject areas. 100% of Home health aide files will be audited monthly for three quarters to ensure that home health aides completed a competency evaluation that addressed all of the required subject areas. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	10/11/2012			

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	<p>A home visit was made to patient number 5 with employee D on 9-20-12 at 8:00 AM. Employee D stated, "No, the nurse did not check me off on a bed bath when they did my skills check."</p> <p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health / personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>				

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G0214	<p>484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA must complete a performance review of each home health aide no less frequently than every 12 months.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure a performance review had been completed at least every 12 months in 1 (file C) of 1 home aide file reviewed of aides that had been employed for greater than 12 months creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence a performance evaluation had been completed. 2. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel file C when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM. 3. The agency's undated "Competency Evaluations" policy states, "Performance Evaluations . . . A formal, written 	G0214	<p>G0214 The Administrator has inserviced on and reviewed agency policies to ensure that a performance review is completed at least every 12 months for aides that have been employed for greater than 12 months. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides a performance review is completed at least every 12 months for aides that have been employed for greater than 12 months The Administrator will be responsible for monitoring these correcrive actions to ensure that this deficiency is corrected and will not recur. This deficiency has been corrected and agency is in compliance.</p>	10/05/2012

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	performance evaluation, based on the applicable job description, shall be completed in accordance with personnel policy requirements but no less than frequently than annually."			

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G0221	<p>484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA must maintain documentation which demonstrates that the requirements of this standard are met.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to maintain documentation that home health aides that provided services on behalf of the agency met the personnel qualification requirements at 42 CFR 484.4 and met the competency evaluation requirements of this section in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 2. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 	G0221	G 0221 The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency agency must have completed the competency evaluation program utilizing a written examination and a competency skills test and documentation maintained of completion of the program. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency completed a competency evaluation program, and that documentation is maintained in their file to confirm the completion of the program. The Administrator will be responsible for monitoring these correcive actions to ensure that this deficiency is corrected and will not recur.	10/12/2012			

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	<p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health /personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>			

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G0222	<p>484.36(b)(6) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA must implement a competency evaluation program that meets the requirements of this paragraph before February 14, 1990. The HHA must provide the preparation necessary for the individual to successfully complete the competency evaluation program. After August 14, 1990, the HHA may use only those aides that have been found to be competent in accordance with §484.36(b).</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides that provided services on behalf of the agency had been found competent in accordance with 484.36(b) in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. 2. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on 	G0222	G 0222The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency agency must have completed the competency evaluation program utilizing a written examination and a competency skills test. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency completed a competency evaluation program, and that documentation is maintained in their file to confirm the completion of the program. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	10/12/2012			

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	<p>behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program.</p> <p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health / personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>				

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G0223	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide is assigned to a specific patient by the registered nurse. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had completed home health aide assignments in 5 (#s 1, 4, 5, 6, & 8) of 5 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed to evidence the registered nurse (RN) had assigned a home health aide to provide care to the patient. 2. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had assigned a home health aide to provide care to the patient. 3. Clinical record number 5 included 	G0223	G 0223The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that Registered Nurses complete Home health aide assignments per agency policy. 60% of all clinical records will be audited monthly for three quarters to ensure that that Registered Nurses completed Home health aide assignments per agency policy. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012

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	<p>physician orders signed by the physician on 7-13-12 and 9-17-12 for home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>4. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>5. Clinical record number 8 included physician orders signed by the physician on 3-11-11 for home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>6. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p>			

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	<p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>7. The agency's undated "Assignments and Staffing" policy states, "Home health aides routinely receive assignments from the supervising nurse or a healthcare professional within the scope of practice of the health care professional providing the supervision."</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review and interview the agency failed to ensure the registered nurse had prepared written patient care instructions for the home health aide in 5 (#s 1, 4, 5, 6, & 8) of 5 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed to evidence the registered nurse (RN) had prepared written patient care instructions for the home health aide. 2. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had prepared written 	G0224	G 0224The Supervising Registered Nurse has inserviced Registered Nurses to ensure that written patient care instructions are prepared for the Home Health Aide 60% of all clinical records will be audited monthly for three quarters to ensure that written patient care instructions are prepared for the Home Health Aide by the Registered Nurse. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur 60% of the clinical records were audited and written patient care instructions were prepared for the Home Health Aide by the Registered nurse in 100% of the chartsTis deficiency has been corrected and agency is in compliance.	10/05/2012	

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	<p>patient care instructions for the home health aide.</p> <p>3. Clinical record number 5 included physician orders signed by the physician on 7-13-12 and 9-17-12 for home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had prepared written patient care instructions for the home health aide.</p> <p>4. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had prepared written patient care instructions for the home health aide.</p> <p>5. Clinical record number 8 included physician orders signed by the physician on 3-11-11 for home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had prepared written patient care instructions for the home health aide.</p> <p>6. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records</p>			

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	<p>and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>				

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G0229	<p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits at least every two (2) weeks per the agency's own policy in 5 (#s 1, 4, 5, 6 and 8) of 5 records of patients that received home health aide services creating the potential to affect the agency's 2 current patients that receive home health aide and SN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's undated "Supervision and Evaluation of Staff" policy states, "A registered nurse or therapist (for therapy only cases) will make a supervisory visit to all clients receiving home health aide services at least every two (2) weeks." 2. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed to evidence the registered nurse (RN) had made any home health aide supervisory 	G0229	G 0229The Supervising Registered Nurse has serviced Registered Nurses other applicable professional staff to ensure that they perform supervisory visits every two weeks per agency policy. 60% of all clinical records will be audited monthly for three quarters to ensure that supervisory visits have been performed every two weeks by the Registered Nurse or other applicable professional staff. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur 60% of the clinical records were audited and Supervisory visits have been performed every two weeks by the Registered nurse in 100% of the charts This deficiency has been corrected and agency is in compliance.	10/08/2012

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	<p>visits.</p> <p>3. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>4. Clinical record number 5 included physician orders dated 7-2-12 and 9-1-12 for SN services 1 time per week for 9 weeks and home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>5. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>6. Clinical record number 8 included physician orders dated 3-9-11 for SN and home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>7. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on</p>			

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	<p>my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>			

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G0235	<p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain organized clinical records and protect health information from possible loss by failing to maintain clinical records in accordance with its own policy in 10 of 10 clinical records reviewed creating the potential to affect all of the agency's 12 current patients (See G 236); failed to ensure clinical record information was safe from loss in 10 of 10 records reviewed creating the potential to affect all of the agency's 12 current patients (See G 239), and failed to ensure the physician had been informed of the availability of a discharge summary in 2 of 2 discharged records reviewed creating the potential to affect all of the agency's 12 current patients (See G 303).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.48 Clinical Records.</p>	G0235	G 0235 The Administrator, has inserviced Registered Nurses on maintaining organized clinical records according to agency policy and notifying the physician of the availability of a discharge summary. 60% of all clinical records will be audited monthly for three quarters to ensure that clinical records have been maintained, organized and health information protected from possible loss, and physician informed of the availability of a discharge summary. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012	

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G0236	<p>484.48 CLINICAL RECORDS 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 clinical record and agency policy review and interview, the agency failed to maintain clinical records in accordance with its own policy in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 clinical records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The agency will maintain a clinical record for all clients . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation . . . The client's clinical record will contain data including but not limited to: Identifying data . . . Name and phone number of an emergency contact person,</p>	G0236	G0236 The Administrator, has inserviced Registered Nurses on maintaining, organized, complete, clinical records according to agency policy including timely filing according to law and regulation 60% of all clinical records will be audited monthly for three quarters to ensure that clinical records are complete, have been maintained, organized and filed timely according to law and regulation. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012			

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	<p>Applicable consent and authorization forms, A complete physical assessment, Comprehensive assessment and OASIS data collection at the specified time frames, Medical history with dates, Primary and secondary diagnosis(es), Homebound status, activity permitted, functional limitations, mental status, Authenticated, legible and complete physician's orders as applicable, Assessment of the client's residence, including safety assessment, adaptability and suitability for home care, Status and availability of caregivers."</p> <p>2. Clinical record number 1 was reviewed on 9-18-12. The record identified a start of care date of 4-7-09 and that home health aide services had been provided. The record failed to include plans of care for services provided after 1-20-12, written summary reports after 7-21-11, home health aide assignment sheets after 11-18-11, home health aide visit notes after 8-23-12, or the patient's medical history.</p> <p>The administrator, employee I, stated, on 9-18-12 at 11:15 AM, "The plans of care are in the computer and the signed ones are somewhere in the office."</p> <p>3. Clinical record number 2 was reviewed on 9-18-12. The record</p>						

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	<p>identified a start of care date of 2-6-12 and that skilled nursing (SN), physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services had been provided. The record failed to include documentation of receipt of patient rights, advance directives information, consent for treatment documentation, plans of care for services provided after 4-5-12, copies of written summary reports sent to the physician, physician verbal orders for recertification of care, or the patient's medical history.</p> <p>4. Clinical record number 3 was reviewed on 9-18-12. The record identified a start of care date of 5-22-12 and that SN and attendant care (ATTC) services had been provided. The record failed to include documentation of receipt of patient rights, advance directives information, consent for treatment documents, SN visit notes after 8-22-12, ATTC visit notes after 8-15-12, copies of written summary reports sent to the physician, any comprehensive assessments, or the patient's medical history.</p> <p>5. Clinical record number 4 was reviewed on 9-18-12. The record identified a start of care date of 3-16-11 and that home health aide services had been provided. The record failed to</p>			

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	<p>include copies of written summary reports sent to the physician, a plan of care for services provided after 9-5-12, home health aide visit notes after 8-24-12, home health aide assignment sheet after 7-11-11, any comprehensive assessments completed after 11-9-11, or the patient's medical history.</p> <p>6. Clinical record number 5 was reviewed on 9-18-12. The record identified a start of care date of 5-2-12 and that SN and home health aide services had been provided. The record failed to include plans of care for services provided from 5-2-12 to 9-2-12, SN visit notes since 8-2-12, any home health aide visit notes, physician verbal recertification orders, any comprehensive assessments, copies of written summary reports sent to the physician, or the patient's medical history.</p> <p>7. Clinical record number 6 was reviewed on 9-18-12. The record identified a start of care date of 12-15-10 and that home health aide services had been provided. The record failed to include a plan of care for the certification period 4-10-12 to 6-10-12, physician verbal recertification orders, comprehensive assessments since 10-12-11, copies of written summary reports sent to the physician, or the</p>						

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	<p>patient's medical history.</p> <p>8. Clinical record number 7 was reviewed on 9-19-12. The record identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced SN and PT services had been provided. The record failed to include plans of care, copies of written summary reports sent to the physician, visit notes for SN services provided from 8-1-12 to 8-20-12; physician verbal orders, communication notes, start of care and recertification comprehensive assessments, or the patient's medical history.</p> <p>The administrator stated, on 9-19-12 at 2:30 PM, "I do have the missing SN visit notes. They are just not in the chart."</p> <p>9. Clinical record number 8 was reviewed on 9-19-12. The record identified a start of care date of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided. The record failed to include documentation of receipt of patient rights and advance directives information, consent for treatment documentation, a discharge summary, a discharge comprehensive assessment, or the patient's medical history.</p>						

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	<p>The administrator stated, on 9-19-12 at 3:05 PM, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>10. Clinical record number 9 was reviewed on 9-20-12. The record identified a start of care date of 2-26-10 and that SN services had been provided. The record failed to include any plans of care, any physician verbal orders, any copies of written summary reports sent to the physician, SN visit notes after 8-16-12, any comprehensive assessments, consent to treat and authorization forms, or the patient's medical history.</p> <p>11. Clinical record number 10 was reviewed on 9-19-12. The record identified a start of care date of 8-8-11 and that SN services had been provided. The record failed to include plans of care for services provided after 6-2-12, SN visit notes after 8-21-12, physician verbal orders, any comprehensive assessments completed after 1-31-12, or the patient's medical history.</p> <p>12. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former</p>				

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	<p>employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>13. On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>			

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G0239	<p>484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure clinical record information was safe from loss in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Upon arrival at the agency, on 9-18-12 at 9:00 AM, observation noted multiple stacks of clinical record information (physician orders, visit notes, plans of care, progress notes) in the front office of the agency on the desk, on the floor, in boxes, and on a round table in the middle of the small office. 2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was 	G0239	G0239The Administrator, has inserviced and reviewed agency policy on Clinical Record Contents and Maintenance that the Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the assessment process . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval." " 60% of all clinical records will be audited monthly for three quarters to ensure that clinical records are maintained for all patients that are complete, assembled and filed in a timely manner and in accordance with law and regulation with active and discharged charts filed in a systematic order to assure timely location and information retrieval. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>terminated.</p> <p>3. A request was made to the administrator, employee I, for clinical records numbered 1, 5, and 9 on 9-18-12 at 10:00 AM. The administrator provided the records to the surveyor at 10:45 AM. The administrator was observed to sort through the multiple stacks of paper in the front office to try and retrieve portions of the clinical records that had been requested. The administrator stated, "I am trying to put the charts back together."</p> <p>4. On 9-18-12 at 1:55 PM, a request was made to the administrator, employee I, for records numbered 7 and 8 (both closed records). These records were not provided.</p> <p>4. Upon arrival at the agency, on 9-19-12 at 1:30 PM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>A. At 1:40 PM, records numbered 7 and 8 (closed records) were again requested from the administrator. Record number 7 was received and the administrator stated, "I'm still working on [getting record number 8]."</p>				

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	<p>B. At 2:20 PM, another request for record number 8 was made to the administrator, employee I.</p> <p>C. Record number 8 was reviewed on 9-19-12 at 3:05 PM. The record failed to include a discharge assessment. The administrator stated, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>5. Upon arrival to the agency, on 9-20-12 at 8:50 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>At 11:00 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>6. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the assessment process . . . The clinical record will be maintained in such a</p>			

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	<p>manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval."</p> <p>7. The agency's undated "Confidentiality and Client Information Security" policy states, "All client information will be protected to reduce the risk of intentional of accidental misuse or loss of confidential information."</p>			

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G0242	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to be in compliance with this condition by failing to ensure written policies were in place to address the overall evaluation of the agency's total program at least annually creating the potential to affect all of the agency's 12 current patients (See G 243); by failing to ensure an evaluation of the agency's total program that included policy and administrative review and a clinical record review had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 244); by failing to ensure an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 245); by failing to ensure the Board of Directors reviewed and acted upon an evaluation of the agency's total program since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 246); by failing to ensure an evaluation of the agency's total program that reviewed the</p>	G0242	G0242The agency has put written policies in place to address the overall evaluation of the agency's total program at least annually that includes policy, administrative and a clinical record review that will assess the agency's appropriateness, adequacy, effectiveness, and efficiency. The Administrator will ensure that an evaluation of the agency's program is completed by 10/15/2012. The Administrator will ensure that the policy is reviewed and signed by 10/17/2012 The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012	

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	<p>administrative practices of the agency to assess the impact of the practices on patient care had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 248); by failing to ensure mechanisms were in place to collect data to assist in an evaluation of the agency's total program creating the potential to affect all of the agency's 12 current patients (See G 249); by failing to ensure clinical record reviews by professionals representing the scope of the program had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 250); and by failing to ensure continuing clinical record review had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients (See G 251).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.52 Evaluation of the Agency's Program.</p>				

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G0243	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. Based administrative record and policy review and interview, the agency failed to ensure written policies were in place to address the overall evaluation of the agency's total program at least annually creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's policy and procedure manual failed to evidence written policies and procedures that addressed an overall annual evaluation of the agency's total program. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she stated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format. 	G0243	The Advisory committe will prepare an overall evaluation of the agency's total program per agency policy with a written summary for the Board of Directors. The Administrator will ensure that the annual evaluation for 2011 is prepared and presented to the board of Directors by 10/17/2012 and yearly thereafter The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012			

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	<p>3. The administrator, employee I, was unable to provide any policies and procedures that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out by the Agency."</p>						

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G0244	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. Based administrative record and policy review and interview, the agency failed to ensure an evaluation of the agency's total program that included policy and administrative review and a clinical record review had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence an evaluation of the agency's total program that included policy and administrative review and clinical record review. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she indicated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format. 	G0244	G 0244The Advisory committee will prepare an overall evaluation of the agency's total program per agency policy with a written summary for the Board of Directors. The Administrator will ensure that the annual evaluation for 2011 is prepared to include policy and administrative review and a clinical record review and presented to the board of Directors by 10/17/2012 and yearly thereafter The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012			

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	<p>The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out by the Agency."</p>			

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G0245	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. Based administrative record and policy review and interview, the agency failed to ensure an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she indicated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format. 	G0245	G 0245The Advisory committee will participate in preparing an overall evaluation of the agency's total program per agency policy with a written summary for the Board of Directors to act on the findings and make recommendations to the agency. The evaluation will assess the agency's appropriateness, adequacy, effectiveness, and efficiency. The Administrator will ensure that the annual evaluation for 2011 is prepared to include policy and administrative review and a clinical record review and assesses the agency's appropriateness, adequacy, effectiveness, and efficiency and presented to the board of Directors by 10/17/2012 and yearly thereafter The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012			

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	<p>The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out by the Agency."</p>				

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G0246	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. Based administrative record and policy review and interview, the agency failed to ensure the Board of Directors reviewed and acted upon an evaluation of the agency's total program since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence the Board of Directors had reviewed and acted upon an evaluation of the agency's total program since the agency's certification in 2004. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she indicated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format. <p>The administrator, employee I, was</p>	G0246	G 0246 The Board of Directors will act on the findings of the Annual evaluation of the agency's total program and make recommendations to the agency. The Administrator will ensure that the Board of Directors receive the annual evaluation for 2011 and make recommendations to the agency by 10/17/2012 and yearly thereafter The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012	

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	<p>unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out by the Agency."</p>			

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G0248	<p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Based administrative record and policy review and interview, the agency failed to ensure an evaluation of the agency's total program that reviewed the administrative practices of the agency to assess the impact of the practices on patient care had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the impact of the agency's administrative practices on patient care had been completed since the agency's certification in 2004. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she indicated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines 	G0248	G 0248The Advisory committee will participate in preparing an overall evaluation of the agency's total program per agency policy with a written summary for the Board of Directors to act on the findings and make recommendations to the agency. The evaluation will assess the agency's appropriateness, adequacy, effectiveness, and efficiency. The Administrator will ensure that the annual evaluation for 2011 is prepared to include policy and administrative review and a clinical record review and assesses the agency's appropriateness, adequacy, effectiveness, and efficiency and presented to the board of Directors by 10/17/2012 and yearly thereafter The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012			

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	<p>according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format.</p> <p>The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0249	<p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>Based administrative record and policy review and interview, the agency failed to ensure mechanisms were in place to collect data to assist in an evaluation of the agency's total program creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence mechanisms to collect data to assist in the evaluation of the agency's total program. 2. The administrator provided 2 documents on 9-20-12 at 1:30 PM that she indicated were the agency's total program evaluation. The document titled "2011 Vital Statistics" listed the number of visits by the different disciplines according to payer source during 2011. The other document (untitled) listed the number of visits by payer source in a different format. <p>The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30</p>	G0249	G 0249 The Administrator has in serviced staff that will be responsible for using the mechanisms the Agency has put in place for the collection of data to assist in the evaluation of the agency's total program including cumulative data summaries in the areas including but not limited to client care, personnel, overall management, and agency statistics. The Administrator will ensure that these mechanisms are used to collect data that will assist in preparing the evaluation of the agency's total program. the efficacy of these mechanisms will be validated after it's use. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/16/2012	

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	<p>PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p> <p>4. The agency's undated "Organizational Guidelines" policy states, "Evaluation: The Agency shall establish procedures that provide for systematic annual evaluation of its program. The process shall include participation by the Advisory Committee in areas of client care, personnel, and overall management/administrative policies and procedures. A written summary of findings is prepared for the Board of Directors, which acts on the findings and makes recommendations to be carried out by the Agency."</p>				

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G0250	<p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based administrative record review and interview, the agency failed to ensure clinical record reviews by professionals representing the scope of the program had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence any quarterly clinical record reviews had been completed. 2. The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them." 3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the 	G0250	G0250The Administratorhas inserved all agency professional staff on the continuing review of clinical record reviews by professionals representing the scope of the program for each 60-day period that a patient receives home care The Administrator will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60 day period that a patient receives home careThe Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/16/2012			

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	agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.			

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G0251	<p>484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care. Based administrative record review and interview, the agency failed to ensure continuing clinical record review had been completed since the agency's certification in 2004 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence any clinical record reviews had been completed. 2. The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them." 3. The administrator, employee I, was unable to provide any other documents that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 	G0251	G 0251The Supervising Registered Nurse has inserviced all agency professional staff on the continuing review of clinical record reviews by professionals representing the scope of the program for each 60-day period that a patient receives home care to determine the adequacy of the plan of care and appropriateness of continuation of care. The Supervising Registered Nurse will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60-day period that a patient receives home care to determine the adequacy of the plan of care and appropriateness of continuation of care. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/17/2012			

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	<p>1:30 PM.</p> <p>4. The agency's undated "Clinical Record Review" policy states, "The supervising nurse shall oversee the clinical record review process, appoint health care professionals to perform review and report to the Agency administration the findings and recommendations . . . Monthly Clinical Record Audits: At least 1 admission, At least 1 discharge record, with the exception of patients discharged to an inpatient facility, Random sample of records, Will include comparison of SOC [start of care] Comprehensive assessment with other documentation from the daily visits and or discharge."</p>			

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G0303	<p>484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been informed of the availability of a discharge summary in 2 (#s 7 and 8) of 2 discharged records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 7 included a verbal discharge order dated 9-6-12 and a discharge summary dated 9-12-12. The record failed to evidence the physician had been informed of the availability of the discharge summary. 2. Clinical record number 8 included a verbal discharge order dated 3-22-11. The record failed to evidence a discharge summary had been completed and failed to evidence the physician had been informed of the availability of a discharge summary. 3. The administrator, employee I, stated, 	G0303	G 0303The Supervising Registered Nurse has in serviced registered nurses on completing discharge summary upon a patient's discharge and informing the attending physician of the availability of a discharge summaryon request60% of discharged records will be audited quarterly for three quarters to ensure that .registered nurses completed discharge summaries upon a patient's discharge and they are filed in the chart and that the attending physician was informed of the of the availability of a discharge summaryon request The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012			

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>4. The agency's undated "Discharge Planning, Discharge Summary and Discharge OASIS" policy states, "A written discharge summary regarding the entire period of care will be prepared within 48 hours of Agency discharge. A copy of the Agency discharge summary will be sent to the physician upon request."</p>						

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G0320	<p>484.20 REPORTING OASIS INFORMATION HHAs must electronically report all OASIS data collected in accordance with §484.55 Based on clinical record and Indiana State Department of Health (ISDH) document review and interview, it was determined the agency failed to electronically report all OASIS data collected by failing to ensure OASIS data had been transmitted within 30 days of completing an assessment in 8 of 8 records reviewed of patients that received skilled services and required the collection of OASIS data creating the potential to affect all of the agency's 6 current patients that receive skilled services (See G 321) and by failing to ensure OASIS data had been transmitted at least monthly in 8 of 8 records reviewed of patients that received skilled services creating the potential to affect all of the agency's 6 current patients that receive skilled services. (G 324).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.20 Reporting OASIS Information.</p>	G0320	G 0320 The Supervising Registered Nurse has inserviced Registered nurses on transmitting OASIS data collected within 30days of completing an assessment and at least monthly for patients that receive skilled services. The Supervising Registered Nurse will audit 100% of OASIS data collected to ensure that they were transmitted within 30 days of completing an assessment and at least monthly for patients that received skilled services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/10/2012	

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G0321	<p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set.</p> <p>Based on clinical record and Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completing an assessment in 8 (patients # 2, 5, 9, 10, 11, 12, 13, and 14) of 8 records reviewed of patients that received skilled services and required comprehensive assessments creating the potential to affect all of the agency's 6 current patients that receive skilled services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a start of care comprehensive assessment completed by the registered nurse (RN), employee E, on 02-06-12. <p>A. ISDH documents failed to evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12 at 9:00 AM and on 9-20-12 at 12:50 PM.</p>	G0321	G 0321The Supervising Registered Nurse has inserviced Registered nurses on transmitting OASIS data collected within 30days of completing an assessment for patients that receive skilled services. The Supervising Registered Nurse will audit 100% of OASIS data collected to ensure that they were transmitted within 30 days of completing an assessment for patients that received skilled services. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/10/2012			

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	<p>2. ISDH documents evidenced a start of care comprehensive assessment had been completed on 5-7-12 for patient number 5 but had not been transmitted until 6-21-12.</p> <p>3. Clinical record number 9 included a recertification comprehensive assessment completed by the RN, employee I, on 2-1-12.</p> <p>A. ISDH documents failed to evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. ISDH documents evidenced a recertification comprehensive assessment had been completed on 3-29-12. The document evidenced the data had not been transmitted until 6-13-12.</p> <p>C. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12 at 9:00 AM and on 9-20-12 at 12:50 PM.</p> <p>4. Clinical record 10 included a recertification comprehensive assessment completed by the RN, employee E, on 1-31-12.</p> <p>A. ISDH documents failed to</p>			

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	<p>evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. ISDH documents evidenced a recertification comprehensive assessment had been completed on 4-25-12 but had not been transmitted until 5-16-12.</p> <p>C. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12 at 9:00 AM and on 9-20-12 at 12:50 PM.</p> <p>5. ISDH documents evidenced a recertification comprehensive assessment had been completed on 3-2-12, a transfer assessment had been completed on 3-12-12, and a resumption of care comprehensive assessment had been completed for patient number 11, but all 3 assessments had not been transmitted until 4-30-12.</p> <p>The ISDH document evidenced a recertification comprehensive assessment had been completed on 5-1-12 but had not been transmitted until 6-13-12.</p> <p>6. ISDH documents evidenced recertification comprehensive assessments had completed on 3-6-12 and 5-3-12 for patient number 12 but had not been transmitted until 6-13-12 and</p>						

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	<p>6-20-12 respectively.</p> <p>7. ISDH documents evidenced a recertification comprehensive assessment had completed on 2-20-12 for patient number 13 but had not been transmitted until 4-30-12.</p> <p>8. ISDH documents evidenced a recertification comprehensive assessment had been completed on 2-29-12 for patient number 14 but had not been transmitted until 6-20-12.</p> <p>A. ISDH documents evidenced a transfer comprehensive assessment had been completed on 4-22-12 but had not been transmitted until 6-21-12.</p> <p>B. ISDH documents evidenced a resumption of care comprehensive assessment had been completed on 4-27-12 but had not been transmitted until 6-21-12.</p> <p>9. The administrator indicated, on 9-18-12 at 9:00 AM, the agency had experienced some difficulties with OASIS data transmission and that the problems were due to a "software" problem.</p>				

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G0324	<p>484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.</p> <p>Based on clinical record and Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completing an assessment in 8 (patients # 2, 5, 9, 10, 11, 12, 13, and 14) of 8 records reviewed of patients that received skilled services and required comprehensive assessments creating the potential to affect all of the agency's 6 current patients that receive skilled services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a start of care comprehensive assessment completed by the registered nurse (RN), employee E, on 02-06-12. <p>A. ISDH documents failed to evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12</p>	G0324	<p>G 0324The Supervising Registered Nurse has serviced Registered nurses on transmitting OASIS data collected within 30days of completing an assessment for patients that receive skilled services and required comprehensive assessments. The Supervising Registered Nurse will audit 100% of OASIS data collected to ensure that they were transmitted within 30 days of completing an assessment for patients that received skilled services and required comprehensive assessments. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	10/10/2012

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	<p>at 9:00 AM and on 9-20-12 at 12:50 PM.</p> <p>2. ISDH documents evidenced a start of care comprehensive assessment had been completed on 5-7-12 for patient number 5 but had not been transmitted until 6-21-12.</p> <p>3. Clinical record number 9 included a recertification comprehensive assessment completed by the RN, employee I, on 2-1-12.</p> <p>A. ISDH documents failed to evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. ISDH documents evidenced a recertification comprehensive assessment had been completed on 3-29-12. The document evidenced the data had not been transmitted until 6-13-12.</p> <p>C. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12 at 9:00 AM and on 9-20-12 at 12:50 PM.</p> <p>4. Clinical record 10 included a recertification comprehensive assessment completed by the RN, employee E, on 1-31-12.</p>				

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	<p>A. ISDH documents failed to evidence the OASIS data gathered at the time of the assessment had been transmitted to the ISDH.</p> <p>B. ISDH documents evidenced a recertification comprehensive assessment had been completed on 4-25-12 but had not been transmitted until 5-16-12.</p> <p>C. The administrator, employee I, was unable to provide any transmission validation reports when asked on 9-18-12 at 9:00 AM and on 9-20-12 at 12:50 PM.</p> <p>5. ISDH documents evidenced a recertification comprehensive assessment had been completed on 3-2-12, a transfer assessment had been completed on 3-12-12, and a resumption of care comprehensive assessment had been completed for patient number 11 but all 3 assessments had not been transmitted until 4-30-12.</p> <p>The ISDH document evidenced a recertification comprehensive assessment had been completed on 5-1-12 but had not been transmitted until 6-13-12.</p> <p>6. ISDH documents evidenced recertification comprehensive assessments had completed on 3-6-12 and 5-3-12 for patient number 12 but had not</p>				

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	<p>been transmitted until 6-13-12 and 6-20-12 respectively.</p> <p>7. ISDH documents evidenced a recertification comprehensive assessment had completed on 2-20-12 for patient number 13 but had not been transmitted until 4-30-12.</p> <p>8. ISDH documents evidenced a recertification comprehensive assessment had been completed on 2-29-12 for patient number 14 but had not been transmitted until 6-20-12.</p> <p>A. ISDH documents evidenced a transfer comprehensive assessment had been completed on 4-22-12 but had not been transmitted until 6-21-12.</p> <p>B. ISDH documents evidenced a resumption of care comprehensive assessment had been completed on 4-27-12 but had not been transmitted until 6-21-12.</p> <p>9. The administrator indicated, on 9-18-12 at 9:00 AM, the agency had experienced some difficulties with OASIS data transmission and that the problems were due to a "software" problem but was unable to provide any documentation and/or additional information that the problems had been addressed.</p>						

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G0330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, the agency failed to provide a comprehensive assessment that reflected the patient's health status and identified patient needs by failing to ensure the registered nurse (RN) had made an initial assessment visit in 3 of 10 records reviewed creating the potential to affect all of the agency's new patients (See G 331); by failing to ensure the RN had made an initial assessment visit within 48 hours or on the physician-ordered start of care date in 3 of</p>	G0330	G 0330The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that comprehensive assessments are made that reflect the patients identified patient needs by making the initial assessment visit within 48 hours or on the physician-ordered start of care date, that the RN completes a comprehensive assessment within 5 calendar days after the start of care, completes an initial comprehensive assessment, that comprehensive start of care and recertification assessments	10/15/2012			

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	10 records reviewed creating the potential to affect all of the agency's new patients (See G 332); by failing to ensure the the RN had completed a comprehensive assessment within 5 calendar days after the start of care in 3 of 10 records reviewed creating the potential to affect all of the agency's 12 current patients (See G 334); by failing to ensure the RN had completed an initial comprehensive assessment in 3 of 10 records reviewed creating the potential to affect all of the agency's new patients (See G 335); by failing to ensure comprehensive start of care and recertification assessments included a review of all medications the patient was using in 9 of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients(See G 337); by failing to ensure comprehensive assessments had been updated the last 5 days of every 60 day period in 9 of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients (See G 339); and by failing to ensure comprehensive assessments had been updated within 48 hours of discharge in 2 of 2 discharge records reviewed creating the potential to affect all of the agency's 12 current patients (See G 341).		include a review of all medications the patient was using, for patients that had been on service for longer than 60 days, comprehensive assessments had been updated the last 5 days of every 60 day period and ensure that comprehensive assessments had been updated within 48 hours of discharge 60% of all clinical records will be audited monthly for three quarters to ensure that that comprehensive assessments are made that reflect the patients identified patient needs by making the initial assessment visit within 48 hours or on the physician-ordered start of care date, that the RN completes a comprehensive assessment within 5 calendar days after the start of care, completes an initial comprehensive assessment, that comprehensive start of care and recertification assessments include a review of all medications the patient was using, for patients that had been on service for longer than 60 days, comprehensive assessments had been updated to the last 5 days of every 60 day period and ensure that comprehensive assessments had been updated within 48 hours of discharge The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will	

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	The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessments of Patients.		not recur	

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G0331	<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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence an initial assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence an initial assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence an initial assessment had been completed. 4. The administrator, employee I, stated, 	G0331	<p>G 0331The Supervising Registered Nurse has inserviced Registered Nurses "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation60% of all clinical records will be audited monthly for three quarters to ensure that the initial comprehensive assessment including OASIS data items of Start of Care (SOC) was initiated within 48 hours of the referral or the physician ordered date (unless the physician has specified a date) or within 48 hours of hospital discharge and that the assessment was completed within 5 days from initiationThe Supervising</p>	10/10/2012			

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician</p>		Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur				

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	ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation."			

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G0332	<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 clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit within 48 hours or on the physician-ordered start of care date in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence an initial assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence an initial assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence an initial assessment had been completed. 4. The administrator, employee I, stated, 	G0332	G 0332The Supervising Registered Nurse has inserviced Registered Nurses to ensure that the registered Nurse makes an initial assessment visit within 48hours of referral or on the physician ordered start of care 60% of all clinical records will be audited monthly for three quarters to ensure that the initial comprehensive assessment was made within 48 hours of the referral or the physician ordered date . The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician</p>			

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	ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation."			

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G0334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed a comprehensive assessment within 5 calendar days after the start of care in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence a comprehensive assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence a comprehensive assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence a comprehensive assessment had been completed. 	G0334	G 0334The Supervising Registered Nurse has serviced Registered Nurses on ensuring that the registered nurse (RN) completes a comprehensive assessment within 5 calendar days after the start of care 60% of all clinical records will be audited monthly for three quarters to ensure that the registered nurse (RN) completes a comprehensive assessment within 5 calendar days after the start of care The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012

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	<p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of</p>						

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	Care (SOC) should be initiated within 48 hours of the referral or the physician ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation."			

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G0335	<p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed a comprehensive assessment in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence a comprehensive assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence a comprehensive assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence a comprehensive assessment had been completed. 4. The administrator, employee I, stated, 	G0335	G 0335The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that the registered nurse (RN) completes all comprehensive assessments 60% of all clinical records will be audited monthly for three quarters to ensure that the registered nurse (RN) completes all comprehensive assessments. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012			

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician</p>			

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	ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation."			

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record review and interview, the agency failed to ensure comprehensive start of care and recertification assessments included a review of all medications the patient was using in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 identified a start of care date of 4-7-09 and that the comprehensive assessment had been updated on 7-21-11 and 11-18-11. The record failed to evidence the comprehensive assessment and the medication review had been updated after 11-18-11. 2. Clinical record number 2 identified a start of care date 2-6-12 and that a start of care comprehensive assessment had been completed on 2-6-12. The record failed 	G0337	G 0337The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that the comprehensive start of care and recertification assessments include a review of all medications the patient was using.60% of all clinical records will be audited monthly for three quarters to ensure that all comprehensive start of care and recertification assessments include a review of all medications the patient is using.The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012			

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	<p>to evidence the comprehensive assessment and the medication review had been updated at any time.</p> <p>3. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence any comprehensive assessments and medication reviews had been completed.</p> <p>4. Clinical record number 4 identified a start of care date of 3-16-11 and that the comprehensive assessment had been updated on 11-9-11. The record failed to evidence the comprehensive assessment and medication review had been updated after 11-9-11.</p> <p>5. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence any comprehensive assessments and medication reviews had been completed.</p> <p>6. Clinical record number 6 identified a start of care date of 12-15-10. The record evidenced the comprehensive assessment had been updated on 4-11-11, 8-10-11, and 10-12-11. The record failed to evidence the comprehensive assessment and medication review had been updated after 10-12-11.</p> <p>7. Clinical record number 7 identified a</p>				

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	<p>start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced the comprehensive assessment had been updated at discharge on 9-12-12. The record failed to evidence a comprehensive assessment and medication review had been completed at start of care or at recertification.</p> <p>8. Clinical record number 9 identified a start of care date of 2-26-10 and that the comprehensive assessment and medication review had been updated on 12-4-11, 2-1-12, and not again until 7-27-12.</p> <p>9. Clinical record number 10 identified a start of care of 8-8-11 and that the comprehensive assessment had been updated on 1-31-12. The record failed to evidence the assessment and medication review had been updated after 1-31-12.</p> <p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was</p>				

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	<p>terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>			

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G0339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments had been updated the last 5 days of every 60 day period in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 identified a start of care date of 4-7-09 and that the comprehensive assessment had been updated on 7-21-11 and 11-18-11. The record failed to evidence the comprehensive assessment had been updated after 11-18-11. 2. Clinical record number 2 identified a start of care date 2-6-12 and that a start of care comprehensive assessment had been 	G0339	G 0339The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that the comprehensive assessments are updated by the Registered Nurse the last 5 days of every 60 day period in patients that had been on service for longer than 60 days 60% of all clinical records will be audited monthly for three quarters to ensure that the comprehensive assessments are updated by the Registered Nurse the last 5 days of every 60 day period in patients that had been on service for longer than 60 days The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012			

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	<p>completed on 2-6-12. The record failed to evidence the comprehensive assessment had been updated at any time.</p> <p>3. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence any comprehensive assessments had been completed.</p> <p>4. Clinical record number 4 identified a start of care date of 3-16-11 and that the comprehensive assessment had been updated on 11-9-11. The record failed to evidence the comprehensive assessment had been updated after 11-9-11.</p> <p>5. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence any comprehensive assessments had been completed.</p> <p>6. Clinical record number 6 identified a start of care date of 12-15-10. The record evidenced the comprehensive assessment had been updated on 4-11-11, 8-10-11, and 10-12-11. The record failed to evidence the comprehensive assessment had been updated after 10-12-11.</p> <p>7. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced the comprehensive assessment had been updated at discharge on 9-12-12.</p>			

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	<p>The record failed to evidence a comprehensive assessment had been completed at start of care or at recertification.</p> <p>8. Clinical record number 9 identified a start of care date of 2-26-10 and that the comprehensive assessment had been updated on 12-4-11, 2-1-12, and not again until 7-27-12.</p> <p>9. Clinical record number 10 identified a start of care of 8-8-11 and that the comprehensive assessment had been updated on 1-31-12. The record failed to evidence the assessment had been updated after 1-31-12.</p> <p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or</p>						

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	<p>information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>11. The agency's undated "Follow-up Comprehensive Assessment and OASIS Collection" policy states, "Specific time points have been identified for completing comprehensive assessment and OASIS data collection and must be collected during a home visit. They are: Within 5 calendar days of each two month interval after the Start of Care (SOC), (in the last 5 days of the certification period; day 56, 57, 58, 59,60)."</p>			

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G0341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments had been updated within 48 hours of discharge in 2 (#s 7 and 8) of 2 discharge records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 7 included a discharge order from the physician dated 9-6-12. The record evidenced the discharge comprehensive assessment had not been updated until 9-12-12, 6 days after the discharge date. The administrator, employee I, stated, on 9-19-12 at 2:30 PM, "The discharge OASIS was not done until 6-12-12 in order to give the patient a 5 day notice of discharge." 2. Clinical record number 8 included a discharge order from the physician dated 3-22-11. The record failed to evidence the comprehensive assessment had been updated at discharge. 	G0341	G 0341The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that the comprehensive assessments had been updated within 48 hours of discharge. 60% of all clinical records will be audited monthly for three quarters to ensure that the comprehensive assessments are updated within 48 hours of discharge.The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/10/2012	

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	<p>The administrator, employee I, indicated, on 9-19-12 at 3:05 PM, the record did not include a discharge OASIS. She stated, "I had it before I gave the chart to you. It's in this office somewhere."</p> <p>3. The agency's undated "Discharge Planning, Discharge Summary and Discharge OASIS" policy states, "Discharge OASIS will be conducted with [sic] 48 hours of (or knowledge of) discharge to the community or death at home."</p>				

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N0000	<p>This was a state home health re-licensure survey.</p> <p>Facility #: 003563</p> <p>Survey Dates: 9-18-12, 9-19-12, and 9-20-12</p> <p>Medicaid Vendor #: 200450280A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>September 28, 2012</p>			N0000			

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N0444	<p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on interview, the administrator failed to ensure complete and accurate administrative and clinical records had been maintained creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The administrator, employee I, was unable to provide documentation and/or any additional information regarding the completion of annual performance evaluations when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM. The administrator failed to provide for review contracts for the provision of physical therapy and speech language pathology services when asked on 9-19-12 at 3:20 PM and on 9-20-12 at 11:10 AM and 12:50 PM. 	N0444	N 0444The Administrator has reviewed the agency's policy on annual performance evaluations, contracts, clinical records, home health aide competency evaluations, clinical record reviews, OASIS data transmission, quality assessment and performance improvement program. The Agency has put in place a policy for the evaluation of the agency's total program, 100% of employee files will be audited quarterly for four quarters to ensure that annual evaluations have been performed on employees that have been employed greater than one year. 100% of all contract files will be audited quarterly for four quarters to ensure that there are contracts for all services provided by contracted providers and are accessible for review 60% of all clinical records will be audited for three quarters for evidence that of maintenance of complete records. 100% of Home health aide files will be audited monthly	10/17/2012			

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	<p>3. The administrator was unable to provide complete clinical records for review. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated. On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in records 1 through 10.</p> <p>4. The administrator was unable to provide documentation and/or additional information regarding the completion of home health aide competency evaluations when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>5. The administrator was unable to provide any policies and procedures that addressed an evaluation of the agency's total program when asked on 9-20-12 at 10:55 AM, 11:10 AM, and 1:30 PM.</p>		<p>for three quarters to ensure that Home health aides that provide services on behalf of the agency completed a competency evaluation program, and that documentation is maintained in their file to confirm the completion of the program. The Administrator will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60 day period that a patient receives home care. 100% of oasis data collected will be audited to ensure that they were transmitted within 30 days of completing an assessment and at least monthly for patients that receive skilled services. The agency's Policy Manual now includes a policy on an evaluation of the agency's total program and the agency's quality assessment and performance improvement program will be monitored quarterly to ensure that it is being performed. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>	

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	<p>6. The administrator was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>7. The administrator indicated, on 9-18-12 at 9:00 AM, the agency had experienced some difficulties with OASIS data transmission and that the problems were due to a "software" problem but was unable to provide any documentation and/or additional information that the problems had been addressed.</p> <p>8. The administrator was unable to provide any documentation and/or information that the agency's quality assessment and performance improvement program had been completed per the agency's own policy. when asked on 9-20-12 at 1:25 PM and 1:45 PM.</p>				

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N0446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on personnel file and agency policy review and interview, the administrator failed to ensure annual performance evaluations had been completed in in 3 (files C, E, and F) of 3 files of individuals employed for greater than 1 year creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed. 2. Personnel file E evidenced the individual had been hired on 2-21-06 to provided skilled nursing on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009. 	N0446	N 446The Administrator has reviewed and inserviced on the agency's policy on annual performance evaluations that annual performance evaluations have to be completed on individuals employed for greater than one year. 100% of employee files will be audited quarterly for four quarters to ensure that annual evaluations have been performed on employees that have been employed greater than one year. The Administrator will responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/12/2012			

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	<p>3. Personnel file F evidenced the individual had been hired on 4-24-03 to provide occupational therapy services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.</p> <p>5. The agency's undated "Supervision and Evaluation of Staff" policy states, "As scheduling allows, the supervisor will make an onsite supervisory visit with each professional staff member, including contract staff, no less often than annually to evaluate performance, client care, coordination of services, organization and time management, documentation and other aspects of performance as indicated . . . As scheduling allows, the supervisor will make or arrange for onsite supervisory visits with each therapist no less often than annually."</p>				

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N0454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to:</p> <ul style="list-style-type: none"> (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; <p>within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure the alternate supervising nurse would be available within a reasonable amount of time creating the potential to affect all of the agency's 12 current patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the entrance conference, on 9-18-12 at 9:00 AM, the administrator, employee I, indicated she also functions as the agency's supervising nurse and that employee G is the agency's alternate administrator and alternate supervising nurse. 2. The agency's administrative records included an undated "Designation of An Alternate" document that states, "In the absence of the supervising nurse, the 	N0454	N 454The administrator has reviewed and inserviced on the agency's policy on Client Acceptance / Staff Assignment policy. The agency has designated a qualified alternate Supervising Registered Nurse who is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency and is in the process of completing the application. The Supervising Registered Nurse will ensure that the desgated alternate is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency. The Supervising Registered Nurse will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur	10/16/2012	

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	<p>authority for the management of clinical services shall be assigned to: [employee G]."</p> <p>3. On 9-20-12 at 9:30 AM, the administrator, employee I, indicated the alternate supervising nurse, employee G, lives in Dallas, Texas, and would not be physically available in the agency if needed in an emergency. The administrator stated, "I know. I plan to make [employee E] the alternate administrator and alternate supervising nurse."</p> <p>4. The agency's undated "Client Acceptance / Staff Assignment" policy states, "The supervising registered nurse or a designated qualified alternate is available on the premises or capable of being reached immediately by phone, pager or other means at all times during the operating hours of the Agency."</p>			

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N0456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based administrative record and agency policy review and interview, the administrator failed to ensure a quality assessment and performance improvement (OAPI) was in place to identify and address existing and potential areas for review and improvement creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Quality Assessment and Performance Improvement Program" policy states, "The agency's quality assessment and performance improvement program consist of but is not limited to the following: Program/staff performance assessment activities; Staff recruitment, training, orientation and continuing education programs; Care conferences; Management meetings; Ongoing review of clinical records; Clinical staff peer</p>	N0456	N456The administrator has ensured that a quality assessment and performance improvement (OAPI) is in place to identify and address existing and potential areas for review and improvement in the agency. Cumulative data will be used quarterly to compile the data. The administrator will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60 day period that a patient receives home care, and data is compiled quarterly from all designated sources quarterly, for all four quarters each year. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	10/16/2012			

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	<p>review activities; Clinical record/utilization review; Clinical staff competency testing program; Review of records requested by peer review; Management systems that support infection control functions; Client/physician/staff satisfaction assessment; Performance improvement plans; Risk management program; Sentinel event action plan; Performance control activities; Annual program evaluation."</p> <p>2. The agency's QAPI documentation for 2012 was provided for review on 9-20-12 at 1:05 PM. The documentation failed to evidence the agency's QAPI program addressed any of the areas required by the agency's own policy.</p> <p>3. The agency's QAPI documentation failed to evidence any quarterly clinical record reviews had been completed. The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p> <p>4. The administrator was unable to provide any additional documentation</p>						

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	and/or information regarding the agency's QAPI program when asked on 9-20-12 at 1:25 PM and 1:45 PM.				

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N0458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel file and agency policy review and interview, the agency failed to ensure personnel files included documentation of annual performance evaluations in 3 (files C, E, and F) of 3 files of individuals employed for greater than 1 year and failed to include documentation of receipt of job description and orientation to the job in 3 (files C, D, and H) of 5 files of individuals hired since the last survey in June 2010 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include: Regarding annual performance evaluations:</p>	N0458	N 458The Administration has inserviced self and staff on Supervision and evaluation of staff as well as completing a formal written performance evaluation.100% of employee files will be audited quarterly to ensure that annual evaluations have been performed on individuals employedfor greater than one year, that employee files include documentation of receipt of job descrption and orientationThe Administrator has scheduled on site supervisory visits with professional staff as their schedules allow to evaluate performance, client care, coordination of services, organization and time management, documentation and other aspects of	10/12/2012	

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	<p>1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed.</p> <p>2. Personnel file E evidenced the individual had been hired on 2-21-06 to provide skilled nursing services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009.</p> <p>3. Personnel file F evidenced the individual had been hired on 4-24-03 to provide occupational therapy services on behalf of the agency. The file failed to evidence an annual performance evaluation had been completed since 2009.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.</p> <p>5. The agency's undated "Supervision and Evaluation of Staff" policy states, "As scheduling allows, the supervisor will make an onsite supervisory visit with each professional staff member, including</p>		<p>performance. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>contract staff, no less often than annually to evaluate performance, client care, coordination of services, organization and time management, documentation and other aspects of performance as indicated . . . As scheduling allows, the supervisor will make or arrange for onsite supervisory visits with each therapist no less often than annually."</p> <p>6. The agency's undated "Competency Evaluations" policy states, "A formal, written performance evaluation, based on the applicable job description, shall be completed in accordance with personnel policy requirements but no less often than annually."</p> <p>Regarding documentation of receipt of job description and orientation to the job:</p> <p>1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence documentation the individual had received orientation to the job.</p> <p>2. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence documentation the individual had received a job description and</p>						

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	<p>orientation to the job.</p> <p>3. Personnel file H evidenced the individual had been hired on 12-16-11 to provide physical therapy services on behalf of the agency. The file failed to evidence documentation the individual had received a job description and orientation to the job.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.</p> <p>5. The agency's undated "Organizational Guidelines" policy states, "Each employee shall acknowledge, in writing, receipt of job description."</p>						

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N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file and clinical record review and interview, the agency failed to ensure employees had undergone a physical examination at least 180 days prior to direct patient contact in 1 (file B) of 5 files of employees hired since the last survey in June 2010 creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. Personnel file B evidenced the individual had been hired on 2-1-12 to provide skilled nursing services on behalf of the agency. The file failed to evidence documentation any physical examination had been completed.</p> <p>Clinical record number 2 evidenced employee B had provided services 3 to 5 times per week to the patient since 2-1-12.</p>	N0462	N 0462The Administrator has inserviced registered nurses on ensuring that employees have undergone a physical examination at least 180 days prior to direct patient contact. 100% of employee health files will be audited monthly for two quarters to ensure that each new hire who will have direct contact with patients has undergone a physical examination at least 180 days prior to direct patient contact. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	10/16/2012	

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	2. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.			

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Centers for Disease Control "Standard Precautions" in 4 (#s 1, 2, 3, and 4) of 4 home visit observations creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions for All Health Care Workers" policy states, "Hand Washing - Hands must be washed before and after contact with each client . . . Gloves - Vinyl or latex medical gloves must be worn when . . . catheter care . . . handling of grossly contaminated linens . . . providing oral hygiene . . . Gloves will be changed between client contact. When gloves are removed, thorough handwashing is required . . . Contaminated waste shall be disposed of in a double-plastic bag and placed in the client's trash container."</p>	N0470	<p>N 0470The Supervising Registered Nurse has in-serviced all healthcare personnel on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practicen including but not limited to hand washing, apprpriate use of gloves, Universal Precautions and hygiene. All healthcare personnel received copies of policies and procedures on Hand washing, Standard Precautions, Blood Borne Pathogens.All Healthcare personnel will attend a mandatory Skills Day on 10/15/2012 during which return demonstrations on hand Washing, Standard Precautions and other Infection control practices will be done by every healthcare personnel. Healthcare personnel will discontinue the practice of not providing services in accordance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions" and healthcare personnel will follow the agency's Infection control policies and procedures and the Centers for Disease Control "Standard</p>	10/15/2012

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	<p>A. The agency's undated "OSHA Regulations / Infection Control / Exposure Control Plan" policy states, "The agency shall maintain polices and procedures for . . . infection control practices by employees which conform with OSHA regulations and currently accepted standards of care."</p> <p>B. The agency's undated "Bloodborne Pathogens" policy states, "Universal precautions will be maintained during the performance of Agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves."</p> <p>C. The agency's undated "Infection Control Program" policy states, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives: . . . To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean</p>		Precautions" when providing care. The Supervising Registered Nurse will make one unannounced visit to each healthcare personnel providing services by 10/15/2012 and each quarter there after for the next three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions." The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur				

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	<p>hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p>			

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	<p>3. A home visit was made to patient number 6 with employee A, a home health aide, on 9-19-12 at 7:55 AM. The aide was observed to don clean gloves without cleansing her hands and assist the patient into the shower. The aide removed her gloves and cleansed her hands and made the patient's bed while the patient bathed. The aide then retrieved 2 pairs of clean gloves and placed them in her pocket, touched the bathroom door knob, and then donned clean gloves from the pocket without cleansing her hands.</p> <p>4. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse (LPN). The patient was observed to be bed bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube were observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked the dressing on the tip of the penis at the foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's</p>			

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	<p>face, head, chest, and arms. The LPN then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand, and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p> <p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and applied a cream to the legs. The LPN removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN</p>			

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	<p>applied the the mask to the patient's face and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p> <p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed control and the siderails while re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the</p>				

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	<p>phone and spoke with the caller. After completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and , using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto the patient's bed. The LPN emptied the container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse</p>						

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	<p>her hands.</p> <p>5. A home visit was made to patient number 3 with employee E, a registered nurse (RN) on 9-19-12 at 12:40 PM. The RN was not observed to wash her hands upon entering the home and starting the visit. The RN took the patient's vital signs and completed an assessment.</p> <p>6. A home visit was made to patient number 5 with employee D, a home health aide, on 9-20-12 at 8:00 AM. The aide washed his hands and assisted the patient to undress and into the shower. Upon request from the patient, the aide washed his hands and donned clean gloves and washed the patient's back. The aide then removed his gloves and failed to cleanse his hands. When the patient had completed the bath, the aide assisted the patient to dry the back and legs. Without cleansing his hands, the aide donned a clean glove to his left hand and applied an over-the-counter pain relief cream to the patient's upper back, shoulders, and knees and applied a different cream to the patient's groin area.</p> <p>After application of the cream to the patient's groin area, the aide removed his glove and failed to cleanse his hands. He then assisted the patient to don an adult disposable brief. The aide removed his</p>				

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	<p>glove and failed to cleanse his hands. The patient completed oral care and ambulated to the bedroom where the aide assisted the patient to don a shirt. Without cleansing his hand, the aide donned a clean glove to the left hand and applied lotion to the patient's legs bilaterally. The aide removed the glove and, without cleansing his hand, assisted the patient to don a stockinet and brace. The aide then assisted the patient to finish dressing and handed the patient the oxygen tubing to re-apply.</p> <p>7. The observations made during home visits numbered 1, 2, and 3 were discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observations.</p>				

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N0472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based administrative record and agency policy review and interview, the agency failed to ensure a quality assessment and performance improvement (OAPI) was in place to identify and address existing and potential areas for review and improvement creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Quality Assessment and Performance Improvement Program" policy states, "The agency's quality assessment and performance improvement program consist of but is not limited to the following: Program/staff performance assessment activities; Staff recruitment, training, orientation and continuing</p>	N0472	<p>N 472The administrator has ensured that a quality assessment and performance improvement (OAPI) is in place to identify and address existing and potential areas for review and improvement in the agency, using cumulative data to address the areas of review and improvementThe administrator will check monthly for three quarters to ensure that clinical record reviews by professionals representing the scope of the program are performed for each 60 day period that a patient receives home care, and data is compiled quarterly from all designated sources quarterly, for all four quarters each year. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	10/16/2012			

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	<p>education programs; Care conferences; Management meetings; Ongoing review of clinical records; Clinical staff peer review activities; Clinical record/utilization review; Clinical staff competency testing program; Review of records requested by peer review; Management systems that support infection control functions; Client/physician/staff satisfaction assessment; Performance improvement plans; Risk management program; Sentinel event action plan; Performance control activities; Annual program evaluation."</p> <p>2. The agency's QAPI documentation for 2012 was provided for review on 9-20-12 at 1:05 PM. The documentation failed to evidence the agency's QAPI program addressed any of the areas required by the agency's own policy.</p> <p>3. The agency's QAPI documentation failed to evidence any quarterly clinical record reviews had been completed. The administrator, employee I, was unable to provide any documentation any clinical record reviews had been completed when asked on 9-20-12 at 1:30 PM. The administrator indicated clinical record reviews had been completed on a quarterly basis but stated, "I can't find them."</p>				

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	4. The administrator was unable to provide any additional documentation and/or information regarding the agency's QAPI program when asked on 9-20-12 at 1:25 PM and 1:45 PM.			

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N0478	<p>410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following:</p> <p>(1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.</p> <p>Based on agency policy review and and interview, the agency failed to provide a written contract for the provision of physical therapy and speech language pathology services creating the potential to affect all of the agency's 12 current patients if physical or speech therapy was needed.</p> <p>The findings include:</p> <p>1. During the entrance conference, on 9-18-12 at 9:00 AM, the administrator, employee I, indicated physical therapy services were provided by employees of</p>	N0478	N0478The administrator has reviewed and inserviced on the agency's policy on Evaluation of Services and Scope of Care. The Administrator will ensure that all contracts are accessible and available for review. 100% of all contract files will be audited quarterly for four quarters to ensure that there are contracts for all services provided by contracted providers and are accessible for review.The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.100% of the contract files were audited to ensure that	10/08/2012	

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	<p>the agency and by a contracted provider. The administrator indicated speech language pathology services were provided by a contracted provider.</p> <p>2. The administrator, employee I, failed to provide for review contracts for the provision of physical therapy and speech language pathology services when asked on 9-19-12 at 3:20 PM and on 9-20-12 at 11:10 AM and 12:50 PM.</p> <p>3. The agency's undated "Evaluation of Services and Scope of Care" policy states, "If personnel under contract are used by the agency or services are furnished under arrangements, there shall be a written contract between those personnel or service provider and the agency."</p>		<p>there are contracts for all services provided by contracted providers and are accessible for review.100% of the charts were accessible for reviewTis deficiency has been corrected and agency is in compliance</p>		

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N0494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of their rights in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future new admissions to the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>A home visit was made to patient</p>	N0494	N 0494The Supervising Registered Nurse has in serviced all Registered Nurses on informing patients of their rights, by providing patients with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment and documenting it.The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the written notice of the client's rights in the admission packet, and post admission, check for	10/10/2012	

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	<p>number 3 on 9-19-12 at 12:40 PM. The patient was unable to locate a home folder provided by the agency that would include a copy of the patient rights.</p> <p>2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with a written notice of patient rights.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p>		<p>documentation that the patient has been informed of their rights, and has been provided with a written notice of their rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment. 60% of admission records will be audted quarterly for evidence that patients have been informed of their rights, and have been provided with a written notice of their rights. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client or the client's family or guardian has the right to be informed of the client's rights through effective means of communication."</p>				

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N0502	<p>410 IAC 17-12-3(b)(2)(C) 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: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of the State home health hotline number in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all of the agency's future admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the State home health hotline number to place a complaint. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the State home health 	N0502	N 0502The Supervising Registered Nurse has in-serviced all Registered Nurses on ensuring that patients or their legal representatives are informed of the State home health hotline in all of the agency's future admissions. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the information the State home health hotline in the admission packet Post admission, the Supervising Registered Nurse will ensure that patients or their legal representatives have been informed of the State home health hotline and that it is documented. 60% of admission records will be audited quarterly for three quarters for evidence that that patients or their legal representatives have been informed of the State home health hotline and that itis	10/10/2012			

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	<p>hotline number to place a complaint.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the State home health hotline number to place a complaint.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client has the right to</p>		documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	

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	place a complaint with the department regarding treatment or care furnished by the agency."			

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N0504	<p>410 IAC 17-12-3(b)(2)(D)(i) 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: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>clinical record and agency policy review and interview, the agency failed to ensure patients had been advised of the disciplines that would furnish care and the proposed frequency of visits in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge 	N0504	N 0504 The Supervising Registered Nurse has in-serviced all Registered Nurses on advising the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished and documenting it. The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition. The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the notice of the disciplines that will furnish care, and the frequency of visits proposed to be furnished in the admission packet. Post admission, the Supervising Registered Nurse will ensure that patients have been advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished	10/10/2012	

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	<p>date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the disciplines that would furnish care and the proposed frequency of visits.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable</p>		<p>and documented. 60% of admission records will be audited quarterly for three quarters for evidence that patients have been advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished and documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The agency shall advice [sic] the client in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."</p>			

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N0505	<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. Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been advised of the right to participate in planning care in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge 	N0505	N 0505The Supervising Registered Nurse has in serviced all Registered Nurses on advising the client in advance of the care to be furnished, any changes in the care to be furnished as follows; the right to participate in planning the care or treatment and in planning changes in the care or treatment. The Registered Nurses have also been serviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log to record the inclusion of the "Patien's Rights" document in the admission packet, and post admission, check that all documents have been signed by the patient or legal representative indicating that the patient has been advised in advance of the right to participate in planning the	10/10/2012	

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	<p>date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the right to participate in planning care.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings</p>		<p>care or treatment and in planning changes in the care or treatment. 60% of admission records will be audted quarterly for evidence that patients have been advised in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>				

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	<p>in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client has the right to participate in the planning of the care. The agency shall advise the client in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment."</p>			

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N0508	<p>410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure confidential clinical record information was maintained in a safe manner to protect patient confidentiality in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Upon arrival at the agency, on 9-18-12 at 9:00 AM, observation noted multiple stacks of clinical record information (physician orders, visit notes, plans of care, progress notes) in the front office of the agency on the desk, on the floor, in boxes, and on a round table in the middle of the small office. 2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put 	N0508	N 508The Administrator has inserviced all healthcare personnel that the patient has the right to confidentiality of the clinical records maintained by the home health agency and the home health agency shall advise the patient of the agency's policy and procedure regarding disclosure of clinical records. To ensure that all client information is maintained in a safe manner to protect patient confidentiality and filed in a timely manner in accordance with law and regulation. 60% of all clinical records will be audted quarterly for evidence that the patient' right to confidentiality of clinical information was maintained, patient was adviced of the agencys policy and procedure regarding disclosure of clinical records, information was assembled and filed in a timely manner and systematic order in accordance with law and regulation, and that all client	10/18/2012			

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	<p>the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>3. A request was made to the administrator, employee I, for clinical records numbered 1, 5, and 9 on 9-18-12 at 10:00 AM. The administrator provided the records to the surveyor at 10:45 AM. The administrator was observed to sort through the multiple stacks of paper in the front office to try and retrieve portions of the clinical records that had been requested. The administrator stated, "I am trying to put the charts back together."</p> <p>4. On 9-18-12 at 1:55 PM, a request was made to the administrator, employee I, for records numbered 7 and 8 (both closed records). These records were not provided.</p> <p>4. Upon arrival at the agency, on 9-19-12 at 1:30 PM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a</p>		<p>information is maintained in a safe manner to protect patient confidentiality The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>				

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	<p>round table in the middle of the small office.</p> <p>A. At 1:40 PM, records numbered 7 and 8 (closed records) were again requested from the administrator. Record number 7 was received and the administrator stated, "I'm still working on [getting record number 8]."</p> <p>B. At 2:20 PM, another request for record number 8 was made to the administrator, employee I.</p> <p>C. Record number 8 was reviewed on 9-19-12 at 3:05 PM. The record failed to include a discharge assessment. The administrator stated, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>5. Upon arrival to the agency, on 9-20-12 at 8:50 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>At 11:00 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small</p>			

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	<p>office.</p> <p>6. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the assessment process . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval."</p> <p>7. The agency's undated "Confidentiality and Client Information Security" policy states, "All client information will be protected to reduce the risk of intentional of accidental misuse or loss of confidential information."</p>				

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N0510	<p>410 IAC 17-12-3(b)(3) Patient Rights Rule 12 Sec. 3(b)(3) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (3) The patient or patient's legal representative has the right under Indiana law to access the patient's clinical records unless certain exceptions apply. The home health agency shall advise the patient or the patient's legal representative of its policies and procedures regarding the accessibility of clinical records.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of the agency's policies and procedures regarding accessing their clinical records in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all of the agency's future admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been informed of the agency's policies and procedures regarding accessing their clinical records. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge 	N0510	<p>N 0510The Supervising Registered Nurse has in serviced all Registered Nurses on advising the client of the agency's policies and procedures regarding accessing their clinical records .The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log to record the inclusion of the Notices of Privcy practices document in the admission packet, and post admission, check that all documents have been signed by the patient or legal representative indicating that the patient has been advised of the agency's policies and procedures regarding accessing their clinical records 60% of admission records will be audted quarterly for evidence that patients have been advised of the agency's policies and procedures regarding accessing their clinical</p>	10/10/2012			

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	<p>date of 3-22-11. The record evidenced SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been informed of the agency's policies and procedures regarding accessing their clinical records.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been informed of the agency's policies and procedures regarding accessing their clinical records.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable</p>		<p>records The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>		

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	<p>to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Client Rights" policy states, "The client or client's legal representative have the right under Indiana law to access the client's clinical records unless certain exceptions apply. The agency shall advise the client or the client's legal representative of it's [sic] policies and procedures regarding the accessibility of clinical records."</p>			

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N0518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been provided with written information regarding advance directives in 3 (#s 3, 8, and 9) of 10 records reviewed creating the potential to affect all future admissions to the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced a start of care date of 5-22-12 and that skilled nurse (SN) and attendant care (ATTC) services were to be provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives. 2. Clinical record number 8 evidenced a start of care of 3-9-11 and a discharge date of 3-22-11. The record evidenced 	N0518	N 0518The Supervising Registered Nurse has in-serviced all Registered Nurses on verbally advising and providing written information to all clients or client's legal representative of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, in advance of treatment and to register complaints concerning advance directives through the home health agencies hotline for the state and documenting it.The Registered Nurses have also been inserviced on the pre and post admission log which will record compliance with this condition.The Supervising Registered Nurse will maintain a pre and post admission log. Pre admission, the Supervising Registered Nurse will ensure the inclusion of the information on advance directives in the admission packet. Post	10/10/2012			

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	<p>SN and home health aide services had been provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives.</p> <p>3. Clinical record number 9 evidenced a start of care date of 2-26-10 and that SN services had been provided 1 time per week. The record failed to evidence the patient had been provided with written information regarding advance directives.</p> <p>4. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>		<p>admission, the Supervising Registered Nurse will ensure that patients or their legal representatives have been verbally advised and provided written information of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state in advance of treatment and documenteingit. 60% of admission records will be audited quarterly for three quarters for evidence that that patients or their legal representatives have been verbally advised and provided written information of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state in advance of treatment and it is documented. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>5. The agency's undated "Client Rights" policy states, "The agency shall inform and distribute written information to the client, in advance, concerning its policies on advance directives, including a description of applicable State law. The agency shall furnish advanced directives information to a client at the time of the first home visit before care is provided."</p> <p>6. The agency's undated "Advance Medical Directive" policy states, "At the time of the initial assessment of client eligibility for service or during the initial visit before care is furnished, the Agency shall: Verbally advise and provide written information to all clients or client's legal representative of their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical treatment, the right to execute an advance directive, and to register complaints concerning advance directives through the home health agencies hotline for the state."</p>				

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure home health aide and skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Patient number 1 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 4-07-09. Clinical record number 1 failed to evidence plans of care signed by the physician for home health aide services provided after 01-20-12.</p> <p>B. Patient number 2 was included on the list of current patients. The list</p>	N0522	N 0522The Supervising Registered Nurse has serviced Registered Nurses on ensuring that care provided is according with a written plan of care established by a physician 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care are signed and dated by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>C. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p>						

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	<p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Patient number 4 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 3-16-11. Clinical record number 4 failed to evidence a plan of care signed by the physician for the certification period 9-6-12 to 11-4-12.</p> <p>The record included home health aide visit notes that evidenced home health aide services had been provided 3 times per week during the certification period.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with</p>				

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	<p>employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence a plan of care signed by the physician for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p> <p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p> <p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p>				

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	<p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any</p>				

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	<p>additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Medical Supervision" policy states, "The physician, dentist, chiropractor, podiatrist or optometrist will provide complete and accurate information about the client and shall sign and date a written medical plan of care and subsequent change orders."</p> <p>The agency's undated "Physician's Plan of Treatment (Care) / Change Orders" policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated by the attending physician . . . The Agency will provide care/services consistent with the plan of care."</p>				

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure clinical records contained plans of care that included all of the required items in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p>	N0524	N 0524The Supervising Registered Nurse has serviced Registered Nurses on ensuring that plans of care include all required items including: 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	10/12/2012			

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	<p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Patient number 1 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 4-07-09. Clinical record number 1 failed to evidence plans of care signed by the physician for home health aide services provided after 01-20-12.</p> <p>B. Patient number 2 was included on the list of current patients. The list evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of</p>		timely discharge or referral, and any other appropriate items. 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care include all required items The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur				

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	<p>motion, and positioning.</p> <p>C. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Patient number 4 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 3-16-11. Clinical record number 4 failed to evidence a plan of care signed by the physician for the certification period 9-6-12 to 11-4-12.</p> <p>The record included home health aide visit notes that evidenced home</p>				

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	<p>health aide services had been provided 3 times per week during the certification period.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence a plan of care signed by the physician for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p>			

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	<p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p> <p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p>						

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	<p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Physician's Plan of Treatment (Care) / Change Orders" policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated by the attending physician . . . The plan of care shall include but not be limited to: Date plan was established, Diagnosis-primary and secondary, Specific discipline, frequency and duration of services, Functional limitations; safety precautions, Mental</p>						

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	status, Homebound status, Prognosis, Medications, allergies, Diet, Medical supplies and equipment, Activity permitted and restricted, Orders for treatment, treatment modalities, laboratory tests, Goals, Discharge plans, including rehabilitation potential and anticipated length of service delivery."			

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N0526	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure plans of care had been reviewed by the physician at least every 2 months in 8 (#s 1, 2, 3, 4, 5, 6, 9, and 10) of 8 active patient records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Clinical record number 1 included a plan of care for the certification period 11-22-11 to 01-20-12 that had been signed by the physician on 12-22-11 The record failed to evidence any plans of care had been reviewed by the physician since 12-22-11. The agency's list of current patients evidenced patient number 1 is currently receiving home health aide services.</p> <p>B. Clinical record number 2 included</p>	N0526	N 0526The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that the total medical plans of care have been reviewed by the physician at least every 60 days. 60% of all clinical records will be audited monthly for three quarters to ensure that plans of care been reviewed by the physician at least every 60 days The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>a plan of care for the certification period 6-5-12 to 8-3-12 and signed by the physician on 6-10-12. The record failed to evidence the physician had reviewed a plan of care since 6-10-12. The agency's list of current patients evidenced patient number 2 is currently receiving skilled nurse (SN) services.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 4 to 5 times per week during the certification period 8-4-12 to 10-2-12.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>C. Clinical record number 3 included a plan of care for the certification period 5-22-12 to 7-20-12 that had been signed by the physician on an unknown date. The record failed to evidence the physician had completed any further review of a plan of care. The agency's list of current patients evidenced patient number 3 is currently receiving SN and homemaker services.</p>			

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	<p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period 07-21-12 to 09-18-12.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p> <p>D. Clinical record number 4 included a plan of care for the certification period 7-8-12 to 9-5-12 that had been signed by the physician on 7-30-12 and that evidenced the agency was to provide home health aide services 3 times per week.</p> <p>1.) The record failed to evidence the physician had reviewed a plan of care for the next certification period, 9-6-12 to 11-4-12.</p> <p>2.) The record evidenced home health aide services had been provided 3 times per week during the certification period 9-6-12 to 11-4-12.</p> <p>E. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and</p>				

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	<p>home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence the physician had reviewed a plan of care for the certification period 9-4-12 to 11-2-12.</p> <p>A home visit was made to patient number 5 on 9-20-12 at 8:00 AM with employee D, a home health aide. The aide was observed to assist the patient with a shower bath and dressing.</p> <p>F. Patient number 6 was included on the list of current patients. The list evidenced the patient received home health aide services with a start of care date of 12-14-10. Clinical record number 6 failed to evidence the physician had reviewed a plan of care for the certification period 8-9-12 to 10-7-12.</p> <p>1.) Clinical record number 6 included home health aide visit notes that evidenced home health aide services had been provided 1 to 2 times per day 7 days per week during the certification period.</p> <p>2.) A home visit was made to patient number 6 on 9-19-12 at 7:55 AM with employee A, a home health aide. The aide was observed to assist the patient with a shower bath, dressing, ambulation, and transfer.</p>			

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	<p>G. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence the physician had reviewed any plans of care for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>H. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence the physician had reviewed a plan of care for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records</p>				

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	<p>and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy states, "The Agency will provide care/services consistent with the plan of care. The plan shall be reviewed by the attending physician in consultation with the Agency's professional staff at such intervals as the client's condition requires but at least every 60 days."</p>				

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N0529	<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> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure written summary reports had been sent to the attending physicians at least every 60 days in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced the agency had provided home health aide services 1 time per week during the certification periods 11-22-11 to 1-20-12, 1-21-12 to 3-20-12, 5-20-12 to 7-18-12, and 7-19-12 to 9-16-12. The record failed to evidence any written summary reports had been sent to the physician for these certification periods. 2. Clinical record number 2 evidenced the agency had provided skilled nursing (SN) services 4 to 5 times per week during the certification periods 2-6-12 to 	N0529	N 0529The Supervising Registered Nurse has in-serviced nursing staff that a written summary report regarding the client's progress is prepared by the case manager for all applicable disciplines participating in the client's care and is submitted to the physician at least every 60 days and a copy of the summary is maintained in the clinical record.60% of all clinical records will be audited quarterly for three quarters for evidence that a written summary report for each patient was sent to the attending physician every 60 days.The Supervising Registered Nurse will be responsible for monitoring these corrective actions to ensure that to ensure that this deficiency is corrected and will not recur.	10/10/2012			

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	<p>4-5-12, 4-6-12 to 6-4-12, 6-5-12 to 8-3-12, and 8-4-12 to 10-2-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>3. Clinical record number 3 evidenced the agency had provided SN and attendant care (ATTC) services 1 time per week during the certification periods 5-22-12 to 7-20-12 and 7-21-12 to 9-18-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>4. Clinical record number 4 evidenced the agency had provided home health aide services 3 times per week during the certification periods 3-10-12 to 5-8-12, 5-9-12 to 7-7-12, and 7-8-12 to 9-5-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>5. Clinical record number 5 evidenced the agency had provided SN 1 time per week and home health aide services 5 times per week during the certification periods 5-7-12 to 7-5-12, 7-6-12 to 9-3-12, and 9-4-12 to 11-2-12. The record failed to evidence any written summary reports had been sent to the physician.</p>				

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	<p>6. Clinical record number 6 evidenced the agency had provided home health aide services 1 to 2 times per day 5 days per week during the certification periods 2-11-12 to 4-10-12, 4-11-12 to 6-9-12, 6-10-12 to 8-8-12, and 8-9-12 to 10-7-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>7. Clinical record number 7 evidenced the agency had provided SN services 3 times per week and physical therapy (PT) services 1 to 2 times per week during the certification period 6-24-12 to 8-22-12 and 8-23-12 to 10-12-12 with a discharge date of 9-6-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>8. Clinical record number 9 evidenced the agency had provided SN services 1 to 2 times per week during the certification periods 12-5-11 to 2-4-12, 2-2-12 to 4-5-12, 4-2-12 to 5-31-12, 6-1-12 to 7-31-12, and 8-1-12 to 9-28-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>9. Clinical record number 10 evidenced the agency had provided SN services 1 time per week during the certification periods 4-4-12 to 6-2-12, 6-3-12 to</p>				

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	<p>8-1-12, and 8-2-12 to 9-30-12. The record failed to evidence any written summary reports had been sent to the physician.</p> <p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>11. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy states, "At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of treatment for review by the</p>						

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	<p>physician. The recertification of physician's order's summary shall include: Changes in client's physical or psychosocial condition, The client's response to care/services, The client's outcome to care/services."</p> <p>12. The agency's undated "Summary Report" policy states, "A summary report regarding the client's progress is prepared by the case manager for all applicable discipline participating in the client's care and is submitted to the physician at least every 60 days. A copy of the summary is maintained in the clinical record."</p>				

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services provided to patients had been in accordance with a written plan of care established by the physician in 5 (#s 2, 3, 5, 9, and 10) of 5 records of patients that received skilled nursing services creating the potential to affect all of the agency's 5 current patients that received skilled nursing services.</p> <p>The findings include:</p> <p>1. A list of the agency's current patients was received from the administrator, employee I, on 9-18-12 at 9:55 AM.</p> <p>A. Patient number 2 was included on the list of current patients. The list evidenced the patient received skilled nurse (SN) services with a start of care date of 2-6-12. Clinical record number 2 failed to evidence a plan of care signed by the physician for the certification period 8-4-12 to 10-2-12.</p> <p>1.) The record included SN visit</p>	N0537	N 0537The Supervising Registered Nurse has serviced Registered Nurses on ensuring that skilled nursing services provided to patients have to be in accordance with a written plan of care established by a physician. 60% of all clinical records will be audited monthly for three quarters to ensure that skilled nursing services provided to patients have to be in accordance with a written plan of care established by the physician. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>notes that evidenced SN services had been provided 4 to 5 times per week during the certification period.</p> <p>2.) A home visit was made with employee B, a licensed practical nurse (LPN), on 9-19-12 at 9:35 AM. The LPN was observed to perform a skilled assessment, administer a breathing treatment with Albuterol and a nebulizer, and perform a total bed bath, range of motion, and positioning.</p> <p>B. Patient number 3 was included on the list of current patients. The list evidenced the patient received SN and homemaker services with a start of care date of 12-08-08. Clinical record number 3 failed to evidence a plan of care signed by the physician for the certification period 7-21-12 to 9-18-12.</p> <p>1.) The record included SN visit notes that evidenced SN services had been provided 1 time per week during the certification period.</p> <p>2.) A home visit was made to patient number 3 on 9-19-12 at 12:45 PM with employee E, a registered nurse (RN). The RN was observed to provide a skilled assessment and teaching to the patient during the visit.</p>			

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	<p>C. Patient number 5 was included on the list of current patients. The list evidenced the patient received SN and home health aide services with a start of care date of 5-7-12. Clinical record number 5 failed to evidence a plan of care signed by the physician for the certification period 9-4-12 to 11-2-12.</p> <p>D. Patient number 9 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 12-5-11. Clinical record number 9 failed to evidence plans of care signed by the physician for services provided after 7-31-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week since 7-31-12.</p> <p>E. Clinical record number 10 was included on the list of current patients. The list evidenced the patient received SN services with a start of care date of 8-8-11. Clinical record number 10 failed to evidence a plan of care signed by the physician for the certification period 8-2-12 to 9-30-12.</p> <p>The record included SN visit notes that evidenced SN services had been provided 1 time per week during the</p>						

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	<p>certification period.</p> <p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>3. The agency's undated "Medical Supervision" policy states, "The physician, dentist, chiropractor, podiatrist or optometrist will provide complete and accurate information about the client and shall sign and date a written medical plan of care and subsequent change. orders."</p> <p>The agency's undated "Physician's Plan of Treatment (Care) / Change Orders"</p>						

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	policy states, "The plan of treatment shall be developed with seven (7) days of the assessment and shall be signed and dated by the attending physician . . . The Agency will provide care/services consistent with the plan of care."			

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N0540	<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. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 3 (#s 3, 5, and 7) of 10 records reviewed creating the potential to affect all of the agency's potential patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence an initial assessment had been completed. 2. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence an initial assessment had been completed. 3. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record failed to evidence an initial assessment had been completed. 4. The administrator, employee I, stated, 	N0540	N0540The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that initial assessment visits are completed and filed in the patient's chart. .60% of all clinical records will be audited monthly for three quarters to ensure that initial assessment visits have been completed and filed in the patient's chart. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>5. The agency's undated "Comprehensive Assessment and OASIS Data Collection Start of Care" policy states, "The initial assessment visit is conducted to determine immediate care and support needs of the client and in the case of Medicare clients to also determine eligibility for the home health benefit including homebound status . . . The initial comprehensive assessment including OASIS data items of Start of Care (SOC) should be initiated within 48 hours of the referral or the physician</p>			

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	ordered date (unless the physician has specified a date) of within 48 hours of hospital discharge. The assessment must be completed within 5 days from initiation."			

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N0541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had updated comprehensive assessments and re-evaluated the patients' nursing needs at least every 60 days in 9 (#s 1, 2, 3, 4, 5, 6, 7, 9, and 10) of 9 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 identified a start of care date of 4-7-09 and that the comprehensive assessment had been updated on 7-21-11 and 11-18-11 by the RN, employee E. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 11-18-11. Clinical record number 2 identified a start of care date 2-6-12 and that a start of care comprehensive assessment had been 	N0541	N 0541The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that comprehensive assessments are updated and the patient's nursing needs every 60 days by the Registered Nurse and filed in the patient's chart. 60% of all clinical records will be audited monthly for three quarters to ensure that comprehensive assessments are updated and the patient's nursing needs every 60 days by the Registered Nurse and filed in the patient's chart. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>completed on 2-6-12 by the RN, employee E. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs at any time after the start of care.</p> <p>3. Clinical record number 3 identified a start of care date of 5-22-12. The record failed to evidence any the RN had completed any comprehensive assessments to re-evaluate the patient's nursing needs.</p> <p>4. Clinical record number 4 identified a start of care date of 3-16-11 and that the RN, employee E, had updated the comprehensive assessment on 11-9-11. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 11-9-11.</p> <p>5. Clinical record number 5 identified a start of care date of 5-2-12. The record failed to evidence the RN had completed any comprehensive assessments to evaluate and re-evaluate the patient's nursing needs.</p> <p>6. Clinical record number 6 identified a start of care date of 12-15-10. The record evidenced the RN, employee E, had updated the comprehensive assessment on</p>			

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	<p>4-11-11, 8-10-11, and 10-12-11. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 10-12-11.</p> <p>7. Clinical record number 7 identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced the RN, employee E, had updated the comprehensive assessment at discharge on 9-12-12. The record failed to evidence the RN had completed a comprehensive at start of care or at recertification to re-evaluate the patient's nursing needs.</p> <p>8. Clinical record number 9 identified a start of care date of 2-26-10 and that the RN, employee I, had updated the comprehensive assessment and re-evaluated the patient's nursing needs on 12-4-11, 2-1-12, and not again until 7-27-12.</p> <p>9. Clinical record number 10 identified a start of care of 8-8-11 and that RN, employee E, had updated the comprehensive assessment and re-evaluated the patient's nursing needs on 1-31-12. The record failed to evidence the RN had updated the comprehensive assessment and re-evaluated the patient's nursing needs after 1-31-12.</p>			

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	<p>10. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>				

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N0553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.</p> <p>Based on agency policy review, observation, and interview, the agency failed to ensure the licensed practical nurse (LPN) had provided services in accordance with the agency's infection control policies and procedures in 1 (employee B) of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Precautions for All Health Care Workers" policy states, "Hand Washing - Hands must be washed before and after contact with each client . . . Gloves - Vinyl or latex medical gloves must be worn when . . . catheter care . . . handling of grossly contaminated linens . . . providing oral hygiene . . . Gloves will be changed between client contact. When gloves are removed, thorough handwashing is required . . . Contaminated waste shall be disposed of in a double-plastic bag and placed in the client's trash container."</p>	N0553	<p>N0553The Supervising Registered Nurse has in-serviced the LPN on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. The LPN received a copy of policies and procedures on Aseptic technique, Standard Precautions, and Blood Borne Pathogens. The LPN will attend a mandatory Skills Day on 10/11/2012 during which she will perform return demonstrations on hand Washing, Standard Precautions and aseptic technique The Supervising Registered Nurse will make weekly unannounced visits to the LPN for two weeks while providing services, then, monthly, and then, once a quarter for three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	10/11/2012	

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	<p>A. The agency's undated "OSHA Regulations/Infection Control/Exposure Control Plan" policy states, "The agency shall maintain polices and procedures for . . . infection control practices by employees which conform with OSHA regulations and currently accepted standards of care."</p> <p>B. The agency's undated "Bloodborne Pathogens" policy states, "Universal precautions will be maintained during the performance of Agency business. If no running water is available, employees will use a hand sanitizer as soon as possible after removing gloves."</p> <p>C. The agency's undated "Infection Control Program" policy states, "The Infection Control Program will be the responsibility of the Agency's leaders and will include the following objectives: . . . To comply with current applicable local, state, and regulatory body regulations, including OSHA and CDC guidelines."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean</p>			

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	<p>hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p>			

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	<p>3. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse (LPN). The patient was observed to be bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube was observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked the dressing on the tip of the penis at the foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's face, head, chest, and arms. The LPN then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p>			

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	<p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and applied a cream to the legs. The LPN removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN applied the the mask to the patient's face and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained</p>						

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	<p>some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p> <p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed control and the siderails while re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the phone and spoke with the caller. After completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and, using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied</p>			

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	<p>the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto the patient's bed. The LPN empties the container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse her hands.</p> <p>4. The observation made the during home visit with patient #2 was discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observation.</p>			

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N0556	<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 observation and interview, the licensed practical nurse (LPN) failed to maintain aseptic technique while preparing equipment for a breathing treatment in 1 (employee B) of 1 LPN observed creating the potential for the spread of disease causing organisms among staff and the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. A home visit was made to patient number 2 on 9-19-12 at 9:35 AM with employee B, a licensed practical nurse (LPN). The patient was observed to be bound, unable to talk, and unable to participate in any way in the ensuing activities. A urinary catheter and gastric feeding tube was observed to be in place. Without cleansing her hands or donning clean gloves, the LPN gathered the supplies for the bath, removed pillows and blankets from the bed, removed uni boots and socks from the patient's feet, removed the patient's shirt and underwear, touched the patient's penis, and checked</p>	N0556	<p>N 0556The Supervising Registered Nurse has in-serviced the LPN on providing care in accordance with the agency's infection control policies and procedures and accepted standards of nursing practice. The LPN received a copy of policies and procedures on Aseptic technique, Standard Precautions, and Blood Borne Pathogens. The LPN will attend a mandatory Skills Day on 10/11/2012 during which she will perform return demonstrations on hand Washing, Standard Precautions and aseptic technique The Supervising Registered Nurse will make weekly unannounced visits to the LPN for two weeks while providing services, then, monthly, and then, once a quarter for three quarters to ensure compliance with the agency's Infection control policies and procedures and the Centers for Disease Control "Standard Precautions The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>	10/11/2012			

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	<p>the dressing on the tip of the penis at the foley catheter insertion site. Without cleansing her hands or donning clean gloves, the aide then washed the patient's face, head, chest, and arms. The LPN then wiped the sweat from her own face with a paper towel and proceeded to continue the bath by washing the patient's left arm, hand and abdomen. The LPN rinsed and dried the patient's face and upper body. At this point the LPN's cellular phone rang. Without cleaning her hands, she reached into her pocket and answered the phone. She indicated the call had not come through. At this time a telephone in the house rang. The LPN answered this phone and spoke to the caller for approximately 1 to 2 minutes.</p> <p>A. After talking on the telephone, the LPN retrieved a bottle of lotion to apply to the patient. The LPN states, "I usually wear gloves when I do this, I don't know why I didn't put some on." Without cleansing her hands, the LPN then donned clean gloves. The LPN applied lotion to the patient's face, neck, arms, hands, and chest. The LPN then applied petroleum jelly to the patient's lips.</p> <p>B. The LPN then prepared to bathe the patient's lower body without changing her gloves or cleansing her hands. She washed and rinsed the patient's legs and</p>						

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	<p>applied a cream to the legs. The LPN removed her gloves and without cleansing her hands, prepared a breathing treatment with Albuterol and a nebulizer. The LPN applied the the mask to the patient's face and connected the tubing to the nebulizer. The LPN then touched the patient's foley catheter tubing and penis and partially rolled and tucked a Chux (a disposable pad) that was soiled with feces under the patient. The LPN then donned cleaned gloves without cleansing her hands. She partially cleansed the patient's rectal area with a wipe and then washed, rinsed, and dried the patient's penis and testicles. The LPN then obtained a container of cream and applied it to the patient's front perineal area. The LPN then tugged her own pants up to her waist. She obtained some tape and placed it onto the dressing on the tip of the patient's penis at the catheter insertion site.</p> <p>C. Without changing gloves or cleansing her hands, the LPN then obtained the patient's stockings, uni boots, and clothing. The aide started to apply the stocking to the right leg and noted the breathing treatment mask had slipped down. She readjusted the mask on the patient's face. The LPN completed the application of the stockings and boots and partially applied the patient's pants up to the knees. She then touched the bed</p>			

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	<p>control and the siderails while re-positioning the patient in the bed. The LPN's cellular phone rang again and she reached into her pocket to retrieve the phone and spoke with the caller. After completing the telephone conversation, the LPN touched the patient's face and neck encouraging the patient to swallow. She turned the patient to the left side and , using the same washcloth as was used on the patient's perineal area, washed and rinsed the patient's back. She then washed, rinsed, and dried the patient's buttocks and rectal area and applied cream to the rectal and groin area.</p> <p>D. After washing the patient's rectal area and without changing her gloves or washing her hands, the LPN then applied the patient's shirt. The LPN then completely removed the Chux soiled with feces and threw it onto the floor. She then adjusted the clean Chux and pulled the patient's pants up. She then touched the feeding tube pump and picked up the soiled Chux off of the floor and threw the Chux into the trash without placing it into a bag. While still wearing the same gloves, the LPN then connected the patient's feeding tube to the pump, gathered the dirty linens, and wiped the sweat from her own face. The LPN emptied the foley catheter and sweat was observed to drip off the LPN's nose onto</p>				

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	<p>the patient's bed. The LPN empties the container with the urine into the toilet and rinsed it. The LPN then removed her gloves and was not observed to cleanse her hands.</p> <p>2. The observation made the during home visit with patient #2 was discussed with the administrator, employee I, on 9-19-12 at 3:20 M. The administrator stated, with regards to patient number 2, "We've been fighting infections." The administrator made no other comments regarding the observation.</p>				

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N0584	<p>410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits at least every two (2) weeks per the agency's own policy in 5 (#s 1, 4, 5, 6 and 8) of 5 records of patients that received home health aide services creating the potential to affect the agency's 2 current patients that receive home health aide and SN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's undated "Supervision and Evaluation of Staff" policy states, "A registered nurse or therapist (for therapy only cases) will make a supervisory visit to all clients receiving home health aide services at least every two (2) weeks." 2. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed to evidence the registered nurse (RN) had 	N0584	<p>N 0584The Supervising Registered Nurse has inserviced Registered Nurses to ensure that they perform supervisory visits every two weeks per agency policy. 60% of all clinical records will be audited monthly for three quarters to ensure that supervisory visits have been performed every two weeks by the Registered Nurse. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur60% of the clinical records were audited and Supervisory visits have been performed every two weeks by the Registered nurse in 100% of the chartsThis deficiency has been corrected and agency is in compliance.</p>	10/08/2012

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	<p>made any home health aide supervisory visits.</p> <p>3. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>4. Clinical record number 5 included physician orders dated 7-2-12 and 9-1-12 for SN services 1 time per week for 9 weeks and home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>5. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>6. Clinical record number 8 included physician orders dated 3-9-11 for SN and home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>7. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put</p>				

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	<p>the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>				

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file and agency policy review and interview, the agency failed to ensure home health aides completed a competency evaluation that addressed all of the required subject areas in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program that addressed any of the required subject areas. 2. Personnel file D evidenced the individual had been hired on 4-18-12 to 	N0596	N 0596The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency meet the personnel qualification requirements, that home health aides that provide services on behalf of the agency have completed a competency evaluation program, that home health aides complete a competency evaluation that addresses all of the required subject areas. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency meet the personnel qualification requirements, that home health aides that provide services on behalf of the agency have completed a competency evaluation program, that home health aides complete a competency evaluation that addresses all of the required subject areas. The Administrator	10/12/2012			

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	<p>provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program that addressed 410 IAC 17-14-1.(h)(9)(A) bed bath.</p> <p>A home visit was made to patient number 5 with employee D on 9-20-12 at 8:00 AM. Employee D stated, "No, the nurse did not check me off on a bed bath when they did my skills check."</p> <p>3. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>4. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health / personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>		will be responsible for monitoring these correcive actions to ensure that this deficiency is corrected and will not recur. .				

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review and interview, the agency failed to check the home health aide registry to ensure the individuals were on the registry and in good standing prior to assigning aides to provide care to patients in 3 (files A, C, and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A evidenced the individual had been hired on 4-27-12 to provide home health aide services. The file failed to evidence the agency had checked the State registry to ensure the individual was in good standing on the registry. 2. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services. The file failed to evidence agency had checked the State registry to ensure the individual was in good standing on the registry. 3. Personnel file D evidenced the 	N0597	N 0597The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency be entered in good standing on the state aide registry. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency are entered to be in good standing on the state aide registryThe Administrator will be responsible for monitoring these correcrive actions to ensure that this deficiency is corrected and will not recur.	10/12/2012

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NAME OF PROVIDER OR SUPPLIER HEALTHSET	STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714
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	<p>individual had been hired on 4-18-12 to provide home health aide services. The file failed to evidence the agency had checked the State registry to ensure the individual was in good standing on the registry.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information when asked on 9-20-12 at 12:15 PM, 12:40 PM, and 1:45 PM.</p>			

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N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to maintain documentation that home health aides that provided services on behalf of the agency met the competency evaluation requirements of this subsection and subsection (h) in 2 (files C and D) of 3 home health aide files reviewed creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A evidenced the individual had been hired on 4-27-12 to provide home health aide services. The file failed to evidence the agency had checked the State registry to ensure the individual was in good standing on the registry. 2. Personnel file C evidenced the individual had been hired on 8-19-11 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. The file 	N0598	<p>N0598The Administrator, has inserviced contractors on ensuring that Home health aides that provide services on behalf of the agency be entered in good standing on the state aide registry. 100% of Home health aide files will be audited monthly for three quarters to ensure that Home health aides that provide services on behalf of the agency are entered to be in good standing on the state aide registryThe Administrator will be responsible for monitoring these correcrive actions to ensure that this deficiency is corrected and will not recur.</p>	10/12/2012			

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	<p>failed to evidence agency had checked the State registry to ensure the individual was in good standing on the registry.</p> <p>3. Personnel file D evidenced the individual had been hired on 4-18-12 to provide home health aide services on behalf of the agency. The file failed to evidence the aide had completed a competency evaluation program. The file failed to evidence agency had checked the State registry to ensure the individual was in good standing on the registry.</p> <p>4. The administrator, employee I, was unable to provide any additional documentation and/or information regarding personnel files C and D when asked on 9-20-12 at 12:40 PM, 12:50 PM and 1:45 PM.</p> <p>5. The agency's undated "Home Health Aide Competency Evaluation Program" policy states, "Each home health/personal care aide shall demonstrate competence for their position as demonstrated by one or more of the following: successful completion of competency evaluation program, be entered and be in good standing on the state aide registry . . . The Agency shall utilize a written examination . . . and a competency skills test."</p>			

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N0602	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases).</p> <p>Based on clinical record and agency policy review and interview the agency failed to ensure the registered nurse had completed home health aide assignments in 5 (#s 1, 4, 5, 6, & 8) of 5 records reviewed of patient that received home health aide services creating the potential to affect all of the agency's 8 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed to evidence the registered nurse (RN) had assigned a home health aide to provide care to the patient. 2. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had assigned a home health aide to provide care to the patient. 	N0602	N 0602The Supervising Registered Nurse has inserviced Registered Nurses on ensuring that Registered Nurses complete Home health aide assignments per agency policy. 60% of all clinical records will be audited monthly for three quarters to ensure that that Registered Nurses completed Home health aide assignments per agency policy. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/12/2012			

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	<p>3. Clinical record number 5 included physician orders signed by the physician on 7-13-12 and 9-17-12 for home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>4. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>5. Clinical record number 8 included physician orders signed by the physician on 3-11-11 for home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had assigned a home health aide to provide care to the patient.</p> <p>6. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was</p>				

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	<p>terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p> <p>7. The agency's undated "Assignments and Staffing" policy states, "Home health aides routinely receive assignments from the supervising nurse or a healthcare professional within the scope of practice of the health care professional providing the supervision."</p>						

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits at least every two (2) weeks per the agency's own policy in 5 (#s 1, 4, 5, 6 and 8) of 5 records of patients that received home health aide services creating the potential to affect the agency's 2 current patients that receive home health aide and SN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's undated "Supervision and Evaluation of Staff" policy states, "A registered nurse or therapist (for therapy only cases) will make a supervisory visit to all clients receiving home health aide services at least every two (2) weeks." 2. Clinical record number 1 included physician orders dated 7-16-12 and 9-14-12 that evidenced the agency was to provide home health aide services 1 time per week for 9 weeks. The record failed 	N0606	N0606The Supervising Registered Nurse has inserviced Registered Nurses other applicable professional staff to ensure that they perform supervisory visits every two weeks per agency policy. 60% of all clinical records will be audited monthly for three quarters to ensure that supervisory visits have been performed every two weeks by the Registered Nurse or other applicable professional staff. The Supervising Registered Nurse is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/08/2012	

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	<p>to evidence the registered nurse (RN) had made any home health aide supervisory visits.</p> <p>3. Clinical record number 4 included plan of care signed by the physician on 7-30-12 for home health aide services 3 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>4. Clinical record number 5 included physician orders dated 7-2-12 and 9-1-12 for SN services 1 time per week for 9 weeks and home health aide services 5 times per week for 9 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>5. Clinical record number 6 included physician orders signed by the physician on 9-19-12 for home health aide services 10 times per week. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>6. Clinical record number 8 included physician orders dated 3-9-11 for SN and home health aide services 1 time per week for 3 weeks. The record failed to evidence the RN had made any home health aide supervisory visits.</p> <p>7. The administrator, employee I, stated,</p>			

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	<p>on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>						

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N0608	<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> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to maintain clinical records in accordance with its own policy in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 clinical records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The agency will maintain a clinical record for all clients . . . The clinical record will be maintained in such a</p>	N0608	N 0608The Administrator, has inserviced Registered Nurses on maintaining, organized, complete, clinical records according to agency policy including timely filing according to law and regulation 60% of all clinical records will be audited monthly for three quarters to ensure that clinical records are complete, have been maintained, organized and filed timely according to law and regulation. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur	10/15/2012			

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	<p>manner that all information is assembled and filed in a timely manner and in accordance with law and regulation . . .</p> <p>The client's clinical record will contain data including but not limited to:</p> <p>Identifying data . . . Name and phone number of an emergency contact person, Applicable consent and authorization forms, A complete physical assessment, Comprehensive assessment and OASIS data collection at the specified time frames, Medical history with dates, Primary and secondary diagnosis(es), Homebound status, activity permitted, functional limitations, mental status, Authenticated, legible and complete physician's orders as applicable, Assessment of the client's residence, including safety assessment, adaptability and suitability for home care, Status and availability of caregivers."</p> <p>2. Clinical record number 1 was reviewed on 9-18-12. The record identified a start of care date of 4-7-09 and that home health aide services had been provided. The record failed to include plans of care for services provided after 1-20-12, written summary reports after 7-21-11, home health aide assignment sheets after 11-18-11, home health aide visit notes after 8-23-12, or the patient's medical history.</p>						

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	<p>The administrator, employee I, stated, on 9-18-12 at 11:15 AM, "The plans of care are in the computer and the signed ones are somewhere in the office."</p> <p>3. Clinical record number 2 was reviewed on 9-18-12. The record identified a start of care date of 2-6-12 and that skilled nursing (SN), physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services had been provided. The record failed to include documentation of receipt of patient rights, advance directives information, consent for treatment documentation, plans of care for services provided after 4-5-12, copies of written summary reports sent to the physician, physician verbal orders for recertification of care, or the patient's medical history.</p> <p>4. Clinical record number 3 was reviewed on 9-18-12. The record identified a start of care date of 5-22-12 and that SN and attendant care (ATTC) services had been provided. The record failed to include documentation of receipt of patient rights, advance directives information, consent for treatment documents, SN visit notes after 8-22-12, ATTC visit notes after 8-15-12, copies of written summary reports sent to the physician, any comprehensive assessments, or the patient's medical</p>			

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	<p>history.</p> <p>5. Clinical record number 4 was reviewed on 9-18-12. The record identified a start of care date of 3-16-11 and that home health aide services had been provided. The record failed to include copies of written summary reports sent to the physician, a plan of care for services provided after 9-5-12, home health aide visit notes after 8-24-12, home health aide assignment sheet after 7-11-11, any comprehensive assessments completed after 11-9-11, or the patient's medical history.</p> <p>6. Clinical record number 5 was reviewed on 9-18-12. The record identified a start of care date of 5-2-12 and that SN and home health aide services had been provided. The record failed to include plans of care for services provided from 5-2-12 to 9-2-12, SN visit notes since 8-2-12, any home health aide visit notes, physician verbal recertification orders, any comprehensive assessments, copies of written summary reports sent to the physician, or the patient's medical history.</p> <p>7. Clinical record number 6 was reviewed on 9-18-12. The record identified a start of care date of 12-15-10 and that home health aide services had</p>				

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	<p>been provided. The record failed to include a plan of care for the certification period 4-10-12 to 6-10-12, physician verbal recertification orders, comprehensive assessments since 10-12-11, copies of written summary reports sent to the physician, or the patient's medical history.</p> <p>8. Clinical record number 7 was reviewed on 9-19-12. The record identified a start of care date of 6-24-12 and a discharge date of 9-6-12. The record evidenced SN and PT services had been provided. The record failed to include plans of care, copies of written summary reports sent to the physician, visit notes for SN services provided from 8-1-12 to 8-20-12; physician verbal orders, communication notes, start of care and recertification comprehensive assessments, or the patient's medical history.</p> <p>The administrator stated, on 9-19-12 at 2:30 PM, "I do have the missing SN visit notes. They are just not in the chart."</p> <p>9. Clinical record number 8 was reviewed on 9-19-12. The record identified a start of care date of 3-9-11 and a discharge date of 3-22-11. The record evidenced SN and home health aide services had been provided. The</p>			

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	<p>record failed to include documentation of receipt of patient rights and advance directives information, consent for treatment documentation, a discharge summary, a discharge comprehensive assessment, or the patient's medical history.</p> <p>The administrator stated, on 9-19-12 at 3:05 PM, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>10. Clinical record number 9 was reviewed on 9-20-12. The record identified a start of care date of 2-26-10 and that SN services had been provided. The record failed to include any plans of care, any physician verbal orders, any copies of written summary reports sent to the physician, SN visit notes after 8-16-12, any comprehensive assessments, consent to treat and authorization forms, or the patient's medical history.</p> <p>11. Clinical record number 10 was reviewed on 9-19-12. The record identified a start of care date of 8-8-11 and that SN services had been provided. The record failed to include plans of care for services provided after 6-2-12, SN visit notes after 8-21-12, physician verbal orders, any comprehensive assessments completed after 1-31-12, or the patient's</p>			

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NAME OF PROVIDER OR SUPPLIER HEALTHSET			STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medical history.</p> <p>12. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>13. On 9-20-12 at 9:10 AM and 12:50 PM, the administrator was asked for any additional documentation and/or information for records numbered 1 through 10. The administrator was unable to provide any further documentation and/or information regarding the findings in the records referenced above.</p>				

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N0614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure clinical record information was safe from loss in 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 records reviewed creating the potential to affect all of the agency's 12 current patients.</p> <p>The findings include:</p> <p>1. Upon arrival at the agency, on 9-18-12 at 9:00 AM, observation noted multiple stacks of clinical record information (physician orders, visit notes, plans of care, progress notes) in the front office of the agency on the desk, on the floor, in boxes, and on a round table in the middle of the small office.</p>	N0614	The Administrator, has inserviced and reviewed agency policy on Clinical Record Contents and Maintenance that the Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the assessment process . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval."60% of all clinical records will be audited monthly for three quarters to ensure that clinical records are maintained for all patients that are complete, assembled and filed in a timely manner and in	10/15/2012	

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	<p>2. The administrator, employee I, stated, on 9-18-12 at 10:20 AM, "I need to put the charts back together. I'm behind on my filing." At 10:45 AM, the administrator indicated a former employee had "misfiled" and "misplaced" many documents in the clinical records and that she was still trying to rectify the situation. The administrator indicated the situation was discovered approximately 2 months ago and the employee was terminated.</p> <p>3. A request was made to the administrator, employee I, for clinical records numbered 1, 5, and 9 on 9-18-12 at 10:00 AM. The administrator provided the records to the surveyor at 10:45 AM. The administrator was observed to sort through the multiple stacks of paper in the front office to try and retrieve portions of the clinical records that had been requested. The administrator stated, "I am trying to put the charts back together."</p> <p>4. On 9-18-12 at 1:55 PM, a request was made to the administrator, employee I, for records numbered 7 and 8 (both closed records). These records were not provided.</p> <p>4. Upon arrival at the agency, on 9-19-12 at 1:30 PM, observation again noted</p>		<p>accordance with law and regulation with active and discharged charts filed in a systematic order to assure timely location and information retrieval. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur</p>		

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	<p>multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>A. At 1:40 PM, records numbered 7 and 8 (closed records) were again requested from the administrator. Record number 7 was received and the administrator stated, "I'm still working on [getting record number 8]."</p> <p>B. At 2:20 PM, another request for record number 8 was made to the administrator, employee I.</p> <p>C. Record number 8 was reviewed on 9-19-12 at 3:05 PM. The record failed to include a discharge assessment. The administrator stated, "I had the discharge OASIS before I gave the chart to you. It's here in the office somewhere."</p> <p>5. Upon arrival to the agency, on 9-20-12 at 8:50 AM, observation again noted multiple stacks of clinical record information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>At 11:00 AM, observation again noted multiple stacks of clinical record</p>			

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	<p>information in the front office on the floor, in boxes, on the desk, and on a round table in the middle of the small office.</p> <p>6. The agency's undated "Clinical Record Contents and Maintenance" policy states, "The Agency will maintain a clinical record for all clients, initiated during the initial visit from data collected during the assessment process . . . The clinical record will be maintained in such a manner that all information is assembled and filed in a timely manner and in accordance with law and regulation. Active and discharged charts will be filed in a systematic order to assure timely location and information retrieval."</p> <p>7. The agency's undated "Confidentiality and Client Information Security" policy states, "All client information will be protected to reduce the risk of intentional of accidental misuse or loss of confidential information."</p>			