

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2012
NAME OF PROVIDER OR SUPPLIER ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1374 N BALDWIN MARION, IN 46953		
(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	
G0000	<p>This visit was for a federal home health complaint investigation.</p> <p>Complaint: IN00 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey date: April 11 - 12, 2012</p> <p>Facility #: 011316</p> <p>Medicaid Vendor #: 200853200</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 17, 2012</p>	G0000			

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

TITLE

(X6) DATE

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

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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 review, policy review, document review, and interview, the agency failed to ensure patients were advised of discharge 5 days in advance per agency policy for 2 of 4 records (Clinical records #2 and 4) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 11/18/11 and discharge 1/16/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy and the patient's rights.</p> <p>a. A clinical record document titled "SN [skilled nurse] discharge" stated, "Pt. [patient] being d/c [discharged] from services as wound is fully healed and no longer requires</p>	G0108	<p>The administrator and Director of Nursing have reviewed federal, state, and company policy on 484.10(c) (1) Right to be informed and participate. The Administrator and Director of Nursing have inserviced and educated all staff on federal, state and company policy on 484.10(c) (1) The Administrator or designee will ensure a 5 day discharge will be given to all clients unless other specified 5 days prior to discharge. Any impending discharges will be reviewed by administrator or designee and be coordinated with family/caregiver, and a unilateral decision will be made prior to discharge. Administrator or designee will audit 10% of clinical records quarterly thru 4-2013 for compliance and to monitor these corrective actions and to ensure that this deficiency is corrected and will not recur.</p>	04/30/2012			

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	<p>services. Patient is ind [independent] with medication, ADL [activities of daily living], and ambulation. No community referrals needed." This document was signed by Employee D on 1/16/12.</p> <p>b. On 4/12/12 at 10:30 AM, Employee D, Registered Nurse (RN), indicated the patient was discharged on 1/16/12 without any notice given to the patient prior to discharge. Employee D indicated the patient's caregiver was educated on 12/2/11 to perform wound care and then no other visits were made. Employee D also indicated a skilled nurse discharge notice was completed on 1/16/12 and there were no other communications with the patient noted in the record from 12/2/11 - 1/16/12.</p> <p>2. Clinical record #4, SOC 1/25/12 and discharge 2/27/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy.</p> <p>On 4/12/12 at 2:30 PM, Employee B indicated the 5 day notice of discharge was not given to the patient per discharge policy.</p> <p>3. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of</p>				

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	<p>admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure:</p> <p>1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client / 'family will participate in this process beginning the with initial assessment visit."</p> <p>4. The agency document titled "Client Orientation to Able Hands Homecare" with no effective date is a ring bound booklet given to patients at the start of care.</p> <p>a. A section of the handbook titled "Section II. Agency Overview" stated, "This book contains general information regarding your rights and responsibilities as a client. There may be additions or changes to this book as necessary when state and federal regulations change ... Discharge, Transfer, or Referral: We will give you, your legal representative or other individual</p>						

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	<p>responsible for your care at least a five calendar days notice before services are stopped ... During the five day notice period, we will try to continue your home care services; however, it may not be possible to do so."</p> <p>b. Section 3 states, "Section III: Your rights and responsibilities as a Healthcare Client: ... The client has the right to receive written notice prior to any discharge or referral in service to the client or the client's legal representative, or other individual responsible for the client's care at least 5 calendar days before the services are stopped."</p>			

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G0144	<p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure effective care coordination occurred for 1 of 4 discharge records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, was given the 5 day discharge notice required by the discharge policy and the patient's rights. There is no documentation that Employee D discussed patient #3's noncompliance with the director of nursing, administrator, or other staff as directed per discharge policy. These concerns were evidenced by the following:</p> <p style="padding-left: 40px;">a. The interdisciplinary note with a date of 1/30/12 and time of 3:30 PM and signature of Employee D stated, "Gave 5 day notice of Medicare noncoverage to patient #3. I explained to [him / her] that we would no longer be able to provide services to [him / her]</p>	G0144	The administrator and Director of Nursing have reviewed federal, state and company policy on 484.14 (g) Coordination of patient services. The Administrator and Director of Nursing inserviced/educated all nursing staff on federal, state, and company policy on 484.14(g) Coordination of patient services. Any impending discharge will be reviewed with other members of the homecare team to assure coordination and continuity with client and family/caregivers. There will be documentation between case managers, Administrator and Director of Nursing for any noted non-compliance issues. Written documentation will be supplied of unilateral decision to discharge client, Administrator, Don, and case manager will be required to sign off on written documentation. The Administrator or designee will audit 10% of clinical records quarterly thru 4/2013 to monitor corrective actions and to ensure that this deficiency is corrected and will not recur.	04/30/2012	

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	<p>2/3/12 due to [his / her] noncompliance. Patient has been directed to make an appointment with the wound clinic and that [he / she] needs a bariatric bed. [He / she] has refused on several occasions to do either of these I explained this again. Patient's caregiver called physician and explained the situation. The physician agreed that if patient was unwilling or unable to comply with going to the wound clinic or to get a bariatric bed [he / she] agreed." The physician stated, "We have no other option." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>b. The clinical record document titled "Physician's orders" stated, "Patient d/c [discharged] from home health services due to noncompliance on 2/3/12." This document was dated 2/3/12.</p> <p>c. The clinical record document titled "SN discharge" dated 2/3/12 and signed by employee D stated, "Patient at time of d/c does not believe [he/she] should be d/c from services. I told pt. [patient] We could retain services if [he / she] was willing to comply c [with] going to the wound clinic and / or trying to get a bariatric bed. Patient again adamantly denied to do either. Pt. was told we would then have to continue c d/c. ... pt.</p>						

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	<p>uses 2 - 3 L [liters] O2 [oxygen] pt. has wound on R [right] great toe and 3 stasis ulcers on R buttock - leg area, all req [required] intervention. Pt's pcp [primary caregiver] was @ [at] the home the day before the d/c and told patient [he / she] would find another nurse / agency to come in and treat those wounds per patient statement ... Patient refused to sign d/c paperwork." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>d. The clinical record document titled, "Summary" with the signature of Employee D on 2/3/12 stated, "Patient received visits every other day from SN for wound care and dressing change ... pt. d/c due to non-compliance. Patient was asked to participate in care by visiting the wound clinic and obtain a bariatric bed. Pt. repeatedly refused to do either. Pt. continues to have wounds that req. nurse interv [intervention]. Review of home safety, fall safety, medication safety, when to contact physician, next appointment, standard precautions ... patient refused to allow review. Written instructions given to patient / caregiver. No, explain. pt. refused and ordered me out of home." The record failed to evidence the patient's noncompliance was discussed with the director of nursing,</p>			

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	<p>administrator, or other staff.</p> <p>e. On 4/12/12 at 2:05 PM, the director of nursing (DON) indicated the noncompliance of patient #3 was not documented as a case conference with any other staff including the DON and / or administrator and this lack of communication did not follow the discharge policy of the agency. The only staff member who documented on this patient during the discharge process was employee D.</p> <p>2. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure: ... 4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family / caregivers."</p> <p>3. The agency policy titled "Coordination of client services" with no effective date</p>				

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	stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction."			

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all treatments for 1 of 4 clinical records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, included a plan of care for the certification period 12/6/11 - 2/3/12 that failed to evidence an order for Ted Hose even though the patient was instructed on wearing Ted hose at nursing visits. A clinical record document titled "Skilled Nurisng visit note" signed by Employee D and completed on 1/25/12 stated, "Pt. [patient] ted hose removed. Old dressing removed."</p> <p>On 4/12/12 at 11 AM, Employee</p>	G0159	The Administrator and Director of Nursing have reviewed federal, state and company policy on 484.18(a) Plan of Care. The Administrator inserviced and educated all nursing staff on federal, state, and company policy on 484.18 (a) Plan of Care. Plan of Care will be completed in full and to include medications, treatments and procedures, All new orders obtained will be included on plan of care, All disciplines involved in plan of care, will be given a copy. All case conferences will include any new orders recieved or discontinued, any noteable changes will be followed up on as ordered on the plan of care. 10% of clincal records will be audited by administrator or designee quarterly thru 4/2013 to ensure all notes are following the plan of care, and that this deficiency is corrected and will not recur.	04/30/2012			

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	<p>D indicated there was no order for Ted hose.</p> <p>2. The agency policy titled "Plan of Care" with no effective date stated, "Home care services are furnished under the supervision and direction of the patient's physician ... An individualized plan of care signed by a physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include Medications, treatment and procedures."</p>			

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse coordinated the patient's care with the director of nursing, administrator, and other staff for 1 of 4 discharge records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, was given the 5 day discharge notice required by the discharge policy and the patient's rights. There is no documentation that Employee D discussed patient #3's noncompliance with the director of nursing, administrator, or other staff as directed per discharge policy. These concerns were evidenced by the following:</p> <p>a. The interdisciplinary note with a date of 1/30/12 and time of 3:30 PM and signature of Employee D stated, "Gave 5 day notice of Medicare noncoverage to</p>	G0176	The Administrator and Director of Nursing have reviewed federal, state and company policy 484.30(a) Duties of a Registered Nurse. The Administrator and Director of Nursing have inserviced and educated all RN's on federal, state, and company policy 484.30 (a) All RN's also inserviced, that any documentation of non-compliance, will be coordinated with Administrator, Director of Nursing, MD and Family/caregiver. Care Coordination form/ IDT note will be used for any non-compliance noted and signed off by Administrator and Director of Nursing. Administrator or desingee will audit 10% of clinical records quarterly thru 04/2013 to monitor corrective actions and to ensure this deficiency is corrected and will not recur.	04/30/2012	

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	<p>patient #3. I explained to [him / her] that we would no longer be able to provide services to [him / her] 2/3/12 due to [his / her] noncompliance. Patient has been directed to make an appointment with the wound clinic and that [he / she] needs a bariatric bed. [He / she] has refused on several occasions to do either of these I explained this again. Patient's caregiver called physician and explained the situation. The physician agreed that if patient was unwilling or unable to comply with going to the wound clinic or to get a bariatric bed [he / she] agreed." The physician stated, "We have no other option." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>b. The clinical record document titled "Physician's orders" stated, "Patient d/c [discharged] from home health services due to noncompliance on 2/3/12." This document was dated 2/3/12.</p> <p>c. The clinical record document titled "SN discharge" dated 2/3/12 and signed by employee D stated, "Patient at time of d/c does not believe [he/she] should be d/c from services. I told pt. [patient] We could retain services if [he / she] was willing to comply c [with] going to the wound clinic and / or trying to get a</p>			

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	<p>bariatric bed. Patient again adamantly denied to do either. Pt. was told we would then have to continue c d/c. ... pt. uses 2 - 3 L [liters] O2 [oxygen] pt. has wound on R [right] great toe and 3 stasis ulcers on R buttock - leg area, all req [required] intervention. Pt's pcp [primary caregiver] was @ [at] the home the day before the d/c and told patient [he / she] would find another nurse / agency to come in and treat those wounds per patient statement ... Patient refused to sign d/c paperwork." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>d. The clinical record document titled, "Summary" with the signature of Employee D on 2/3/12 stated, "Patient received visits every other day from SN for wound care and dressing change ... pt. d/c due to non-compliance. Patient was asked to participate in care by visiting the wound clinic and obtain a bariatric bed. Pt. repeatedly refused to do either. Pt. continues to have wounds that req. nurse interv [intervention]. Review of home safety, fall safety, medication safety, when to contact physician, next appointment, standard precautions ... patient refused to allow review. Written instructions given to patient / caregiver. No, explain. pt. refused and ordered me</p>				

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	<p>out of home." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>e. On 4/12/12 at 2:05 PM, the director of nursing (DON) indicated the noncompliance of patient #3 was not documented as a case conference with any other staff including the DON and / or administrator and this lack of communication did not follow the discharge policy of the agency. The only staff member who documented on this patient during the discharge process was employee D.</p> <p>2. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure: ... 4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family / caregivers."</p>				

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	3. The agency policy titled "Coordination of client services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction."			

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N0484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure effective care coordination occurred for 1 of 4 discharge records reviewed (Clinical record #3).</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, was given the 5 day discharge notice required by the discharge policy and the patient's rights. There is no documentation that Employee D discussed patient #3's noncompliance with the director of nursing, administrator, or other staff as directed per discharge policy. These concerns were evidenced by the following:</p> <p style="padding-left: 40px;">a. The interdisciplinary note with a date of 1/30/12 and time of 3:30 PM and signature of Employee D stated, "Gave 5 day notice of Medicare noncoverage to patient #3. I explained to [him / her] that we would no longer be able to provide services to [him / her]</p>	N0484	The Administrator and Director of Nursing have reviewed state, federal and company policy for 410 IAC 17-12-2 (g) QA and Performance improvement. The Administrator and Director of Nursing inserviced/educated all nursing staff on federal, state, and company policy 410 IAC 17-12-2 (g) QA and Performance improvement. There will be documentation between case managers, Administrator and Director of Nursing for any noted non-compliance issues written documentation in the form of an IDT note or Care Coordination. Administrator, Don, and case manager will be required to sign off on written documentation. The Administrator or designee will audit 10% of clinical records quarterly thru 4/2013 to monitor corrective actions and to ensure that this deficiency is corrected and will not recur.	04/30/2012			

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	<p>2/3/12 due to [his / her] noncompliance. Patient has been directed to make an appointment with the wound clinic and that [he / she] needs a bariatric bed. [He / she] has refused on several occasions to do either of these I explained this again. Patient's caregiver called physician and explained the situation. The physician agreed that if patient was unwilling or unable to comply with going to the wound clinic or to get a bariatric bed [he / she] agreed." The physician stated, "We have no other option." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>b. The clinical record document titled "Physician's orders" stated, "Patient d/c [discharged] from home health services due to noncompliance on 2/3/12." This document was dated 2/3/12.</p> <p>c. The clinical record document titled "SN discharge" dated 2/3/12 and signed by employee D stated, "Patient at time of d/c does not believe [he/she] should be d/c from services. I told pt. [patient] We could retain services if [he / she] was willing to comply c [with] going to the wound clinic and / or trying to get a bariatric bed. Patient again adamantly denied to do either. Pt. was told we would then have to continue c d/c. ... pt.</p>			

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	<p>uses 2 - 3 L [liters] O2 [oxygen] pt. has wound on R [right] great toe and 3 stasis ulcers on R buttock - leg area, all req [required] intervention. Pt's pcp [primary caregiver] was @ [at] the home the day before the d/c and told patient [he / she] would find another nurse / agency to come in and treat those wounds per patient statement ... Patient refused to sign d/c paperwork." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>d. The clinical record document titled, "Summary" with the signature of Employee D on 2/3/12 stated, "Patient received visits every other day from SN for wound care and dressing change ... pt. d/c due to non-compliance. Patient was asked to participate in care by visiting the wound clinic and obtain a bariatric bed. Pt. repeatedly refused to do either. Pt. continues to have wounds that req. nurse interv [intervention]. Review of home safety, fall safety, medication safety, when to contact physician, next appointment, standard precautions ... patient refused to allow review. Written instructions given to patient / caregiver. No, explain. pt. refused and ordered me out of home." The record failed to evidence the patient's noncompliance was discussed with the director of nursing,</p>			

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	<p>administrator, or other staff.</p> <p>e. On 4/12/12 at 2:05 PM, the director of nursing (DON) indicated the noncompliance of patient #3 was not documented as a case conference with any other staff including the DON and / or administrator and this lack of communication did not follow the discharge policy of the agency. The only staff member who documented on this patient during the discharge process was employee D.</p> <p>2. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure: ... 4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family / caregivers."</p> <p>3. The agency policy titled "Coordination of client services" with no effective date</p>				

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	stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction."			

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N0488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on clinical record review, policy review, document review, and interview, the agency failed to ensure patients were advised of discharge 5 days in advance for 2 of 4 records (Clinical records #2 and 4) with the potential to affect all the agency's patients.</p>	N0488	The Administrator and Director of Nursing have reviewed state, federal and company policy on 410 IAC 17-12-2 (i) and (j). The Administrator and Director of Nursing have inserviced nursing staff on state, federal and company policy on 410 IAC 17-12-2 (i) and (j). Agency handbook will be updated to match company policy.Nursing	04/30/2012			

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	<p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 11/18/11 and discharge 1/16/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy and the patient's rights.</p> <p style="padding-left: 40px;">a. A clinical record document titled "SN [skilled nurse] discharge" stated, "Pt. [patient] being d/c [discharged] from services as wound is fully healed and no longer requires services. Patient is ind [independent] with medication, ADL [activities of daily living], and ambulation. No community referrals needed." This document was signed by Employee D on 1/16/12.</p> <p style="padding-left: 40px;">b. On 4/12/12 at 10:30 AM, Employee D, Registered Nurse (RN), indicated the patient was discharged on 1/16/12 without any notice given to the patient prior to discharge. Employee D indicated the patient's caregiver was educated on 12/2/11 to perform wound care and then no other visits were made. Employee D also indicated a skilled nurse discharge notice was completed on 1/16/12 and there were no other communications with the patient noted in the record from 12/2/11 - 1/16/12.</p> <p>2. Clinical record #4, SOC 1/25/12 and</p>		<p>staff to also be educated on discharge process begins at admission. The Administrator or designee will ensure a 5 day discharge will be given to all clients unless other specified 5 days prior to discharge. Any impending discharges will be reviewed by administrator or designee and be coordinated with family/caregiver, and a unilateral decision will be made prior to discharge. Administrator or designee will audit 10% of clinical records quarterly thru 4-2013 for compliance and to monitor these corrective actions and to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>discharge 2/27/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy.</p> <p>On 4/12/12 at 2:30 PM, Employee B indicated the 5 day notice of discharge was not given to the patient per discharge policy.</p> <p>3. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure:</p> <p>1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client / 'family will participate in this process beginning the with initial assessment visit."</p> <p>4. The agency document titled "Client Orientation to Able Hands Homecare" with no effective date is a ring bound</p>						

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	<p>booklet given to patients at the start of care.</p> <p>a. A section of the handbook titled "Section II. Agency Overview" stated, "This book contains general information regarding your rights and responsibilities as a client. There may be additions or changes to this book as necessary when state and federal regulations change ... Discharge, Transfer, or Referral: We will give you, your legal representative or other individual responsible for your care at least a five calendar days notice before services are stopped ... During the five day notice period, we will try to continue your home care services; however, it may not be possible to do so."</p> <p>b. Section 3 states, "Section III: Your rights and responsibilities as a Healthcare Client: ... The client has the right to receive written notice prior to any discharge or referral in service to the client or the client's legal representative, or other individual responsible for the client's care at least 5 calendar days before the services are stopped."</p>						

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N0506	<p>410 IAC 17-12-3(b)(2)(D)(iii) 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: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.</p> <p>Based on clinical record review, policy review, document review, and interview, the agency failed to ensure patients were advised of discharge 5 days in advance per agency policy for 2 of 4 records (Clinical records #2 and 4) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 11/18/11 and discharge 1/16/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy and the patient's rights.</p> <p>a. A clinical record document titled "SN [skilled nurse] discharge" stated, "Pt. [patient] being d/c [discharged] from services as wound is fully healed and no longer requires services. Patient is ind [independent]"</p>	N0506	The Administrator and Director of Nursing have reviewed state, federal and company policy on 410 IAC 17-12-3(b) (2)(D)(iii) Patient Rights. The Administrator and Director of Nursing have inserviced nursing staff on state, federal and company policy on 410 IAC 17-12-3(b) (2)(D)(iii) Patient Rights. Agency handbook will be updated to match company policy. Nursing staff to also be educated on discharge process begins at admission. The Administrator or designee will ensure a 5 day discharge will be given to all clients unless other specified 5 days prior to discharge. Any impending discharges will be reviewed by administrator or designee and be coordinated with family/caregiver, and a unilateral decision will be made prior to discharge. Administrator or designee will audit 10% of clinical records quarterly thru 4-2013 for compliance and to monitor these	04/30/2012			

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	<p>with medication, ADL [activities of daily living], and ambulation. No community referrals needed." This document was signed by Employee D on 1/16/12.</p> <p>b. On 4/12/12 at 10:30 AM, Employee D, Registered Nurse (RN), indicated the patient was discharged on 1/16/12 without any notice given to the patient prior to discharge. Employee D indicated the patient's caregiver was educated on 12/2/11 to perform wound care and then no other visits were made. Employee D also indicated a skilled nurse discharge notice was completed on 1/16/12 and there were no other communications with the patient noted in the record from 12/2/11 - 1/16/12.</p> <p>2. Clinical record #4, SOC 1/25/12 and discharge 2/27/12, failed to evidence the patient was given the 5 day discharge notice required by the discharge policy.</p> <p>On 4/12/12 at 2:30 PM, Employee B indicated the 5 day notice of discharge was not given to the patient per discharge policy.</p> <p>3. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to</p>		corrective actions and to ensure that this deficiency is corrected and will not recur.				

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	<p>facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure:</p> <p>1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client / 'family will participate in this process beginning the with initial assessment visit."</p> <p>4. The agency document titled "Client Orientation to Able Hands Homecare" with no effective date is a ring bound booklet given to patients at the start of care.</p> <p>a. A section of the handbook titled "Section II. Agency Overview" stated, "This book contains general information regarding your rights and responsibilities as a client. There may be additions or changes to this book as necessary when state and federal regulations change ... Discharge, Transfer, or Referral: We will give you, your legal representative or other individual responsible for your care at least a five</p>				

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	<p>calendar days notice before services are stopped ... During the five day notice period, we will try to continue your home care services; however, it may not be possible to do so."</p> <p>b. Section 3 states, "Section III: Your rights and responsibilities as a Healthcare Client: ... The client has the right to receive written notice prior to any discharge or referral in service to the client or the client's legal representative, or other individual responsible for the client's care at least 5 calendar days before the services are stopped."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2012	
NAME OF PROVIDER OR SUPPLIER ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1374 N BALDWIN MARION, IN 46953			
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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all treatments for 1 of 4 clinical records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, included a plan of</p>	N0524	The Administrator and Director of Nursing have reviewed state, federal and company policy 410 IAC 17-13-1(a)(1) Patient Care. The Administrator and Director of Nursing have inserviced on state, federal, and company policy 410 IAC 17-13-1(a)(1) Patient Care. Plan of Care will be completed in full and to include medications, treatments and procedures, All new orders obtained will be included on plan of care, All disciplines involved in plan of	04/30/2012			

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	<p>care for the certification period 12/6/11 - 2/3/12 that failed to evidence an order for Ted Hose even though the patient was instructed on wearing Ted hose at nursing visits. A clinical record document titled "Skilled Nurisng visit note" signed by Employee D and completed on 1/25/12 stated, "Pt. [patient] ted hose removed. Old dressing removed."</p> <p>On 4/12/12 at 11 AM, Employee D indicated there was no order for Ted hose.</p> <p>2. The agency policy titled "Plan of Care" with no effective date stated, "Home care services are furnished under the supervision and direction of the patient's physician ... An individualized plan of care signed by a physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include Medications, treatment and procedures."</p>		<p>care, will be given a copy. All case conferences will include any new orders recieved or discontinued, any noteable changes will be followed up on as ordered on the plan of care. 10% of clinical records will be audited by administrator or designee quarterly thru 4/2013 to ensure all notes are following the plan of care, and that this deficiency is corrected and will not recur.</p>		

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse coordinated the patient's care with the director of nursing, administrator, and other staff for 1 of 4 discharge records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 6/9/11 and discharge 2/3/12, was given the 5 day discharge notice required by the discharge policy and the patient's rights. There is no documentation that Employee D discussed patient #3's noncompliance with the director of nursing, administrator, or other staff as directed per discharge policy. These concerns were evidenced by the following:</p> <p style="padding-left: 40px;">a. The interdisciplinary note with a date of 1/30/12 and time of 3:30 PM and signature of Employee D stated, "Gave 5 day notice of Medicare</p>	N0545	The Administrator and Director of Nursing have reviewed federal, state and company policy 410 IAC 17-14-1(a)(1)(F) Scope of Services. The Administrator and Director of Nursing have inserviced and educated all RN's on federal, state, and company policy 410 IAC 17-14-1(a)(1)(F) Scope of Services All RN's also inserviced, that any documentation of non-compliance, will be coordinated with Administrator, Director of Nursing, MD and Family/caregiver. Care Coordination form/ IDT note will be used for any non-compliance noted and signed off by Administrator and Director of Nursing. Administrator or desingee will audit 10% of clinical records quarterly thru 04/2013 to monitor corrective actions and to ensure this deficiency is corrected and will not recur.	04/30/2012			

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	<p>noncoverage to patient #3. I explained to [him / her] that we would no longer be able to provide services to [him / her] 2/3/12 due to [his / her] noncompliance. Patient has been directed to make an appointment with the wound clinic and that [he / she] needs a bariatric bed. [He / she] has refused on several occasions to do either of these I explained this again. Patient's caregiver called physician and explained the situation. The physician agreed that if patient was unwilling or unable to comply with going to the wound clinic or to get a bariatric bed [he / she] agreed." The physician stated, "We have no other option." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>b. The clinical record document titled "Physician's orders" stated, "Patient d/c [discharged] from home health services due to noncompliance on 2/3/12." This document was dated 2/3/12.</p> <p>c. The clinical record document titled "SN discharge" dated 2/3/12 and signed by employee D stated, "Patient at time of d/c does not believe [he/she] should be d/c from services. I told pt. [patient] We could retain services if [he / she] was willing to comply c [with] going to the wound clinic and / or trying to get a</p>				

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	<p>bariatric bed. Patient again adamantly denied to do either. Pt. was told we would then have to continue c d/c. ... pt. uses 2 - 3 L [liters] O2 [oxygen] pt. has wound on R [right] great toe and 3 stasis ulcers on R buttock - leg area, all req [required] intervention. Pt's pcp [primary caregiver] was @ [at] the home the day before the d/c and told patient [he / she] would find another nurse / agency to come in and treat those wounds per patient statement ... Patient refused to sign d/c paperwork." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>d. The clinical record document titled, "Summary" with the signature of Employee D on 2/3/12 stated, "Patient received visits every other day from SN for wound care and dressing change ... pt. d/c due to non-compliance. Patient was asked to participate in care by visiting the wound clinic and obtain a bariatric bed. Pt. repeatedly refused to do either. Pt. continues to have wounds that req. nurse interv [intervention]. Review of home safety, fall safety, medication safety, when to contact physician, next appointment, standard precautions ... patient refused to allow review. Written instructions given to patient / caregiver. No, explain. pt. refused and ordered me</p>				

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	<p>out of home." The record failed to evidence the patient's noncompliance was discussed with the director of nursing, administrator, or other staff.</p> <p>e. On 4/12/12 at 2:05 PM, the director of nursing (DON) indicated the noncompliance of patient #3 was not documented as a case conference with any other staff including the DON and / or administrator and this lack of communication did not follow the discharge policy of the agency. The only staff member who documented on this patient during the discharge process was employee D.</p> <p>2. The agency policy titled "Client discharge process" with no effective date stated, "Discharge planning is initiated for every home care client at the time of admission for home care ... Purpose: to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed, to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency. Special instructions: Discharge Procedure: ... 4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family / caregivers."</p>						

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	3. The agency policy titled "Coordination of client services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction."			