

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157472	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2012
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NAME OF PROVIDER OR SUPPLIER ADDUS HEALTHCARE (INDIANA) INC	STREET ADDRESS, CITY, STATE, ZIP CODE 674 N 36TH ST LAFAYETTE, IN 47905
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G0000	<p>This was a federal home health recertification survey which resulted in an extended survey on 12/27/12.</p> <p>Facility provider number: 009467</p> <p>Survey dates: December 27, 28, and 31, 2012</p> <p>Medicaid vender number: 200928760FW</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor Ingrid Miller, RN, Public Health Nurse Surveyor</p> <p>Unduplicated admissions: 149</p> <p>Clinical record review: 13 Home Visits: 2</p> <p>Addus Healthcare Indiana, Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found was found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information.</p>	G0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2013

FORM APPROVED

OMB NO. 0938-0391

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	Quality Review: Joyce Elder, MSN, BSN, RN January 7, 2013				

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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 review and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 6 of 13 clinical records reviewed with the potential to affect all the patients of the agency. (# 2, 3, 6, 7, 8, and 12)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of care 11/15/12, failed to evidence the patient nor their guardian had been notified of the patient rights. 2. On December 28, 2012, at 4:30 PM, the administrator indicated there was no further information. 	G0101	<p>The Patient's Notice of Rights are included in the Patient Handbook that is in the Start of Care packets. Effective 1/3/2013, the registered nurse conducting the initial assessment reviews/advises the patient or patient's representative of their rights both verbally and in writing prior to formal admission. A checklist has been developed and is included in the Start of Care packets. Upon completion of advising the patient or patient's representative of their rights the RN will document this on the checklist. The checklist will be submitted with the completed start of care paperwork and is filed in the patient's record. All Field Clinicians and Administrative staff were in-serviced on policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation. The Performance Improvement Coordinator and/or designee will review 100% of the new admission records on a monthly basis to ensure compliance. When 100% compliance has been achieved the audits will be performed on a quarterly basis. 100% of all new admission records will continue to be reviewed. The</p>	01/03/2013	

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	3. Clinical records #3, #6, #7, #8, and #12 failed to evidence the agency had informed the patient or the patient's legal representatives of their rights.		Administrator is responsible for monitoring the Performance Improvement Coordinator and ensuring that reviews are completed. See exhibit #G101		

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G0111	<p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS</p> <p>The patient has the right to confidentiality of the clinical records maintained by the HHA. Based on interview and review of policy, it was determined the agency failed to ensure confidentiality of patient identifiable information and OASIS data items for 1 of 1 agency reviewed with the potential to affect all current and past patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/27/12 at 1:10 PM, employee A indicated an individual who was not an employee of the agency transmitted all the OASIS assessment items for all agency patients and provided the transmission validation reports to the agency via electronic mail. On 12/27/12 at 3 PM, employee A indicated there was not a written contract between the individual responsible for the transmission of the OASIS data items and provision of validation reports to the agency. He indicated the patients were not informed that their information was going to be shared with this individual outside of the agency. The policy titled "OASIS - OUTCOME AND ASSESSMENT 	G0111	<p>Administrator/Agency Director is responsible for maintaining the standard. Per Addus policy, "Oasis – Outcome and Assessment Information Set" 2.14.0, dated 4/14/2011, paragraph 14, under sub heading "procedure", " Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data." An employee of Addus Healthcare, Inc. was responsible for the transmission of locked OASIS assessments, but the employee was not located at the Agency. Administrator/Agency Director provided a copy of the employee's signed job description, outlining her role in OASIS data transmission, her signed HIPAA statement and her non-disclosure agreement. Per 42 CFR 484.11, it was determined that the employee was not a direct employee of the agency and thus required a written contract. On January 7 th , 2013, A HIPAA Business Associate Agreement was mutually executed to address 42 CFR 484.11. According to Article IV "Term and Termination", number 1 "Term", the agreement shall be effective the first day of</p>	01/07/2013	

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	INFORMATION SET / COMPREHENSIVE ASSESSMENTS" stated, "Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data."		the Business Associates employment and shall run through the duration of the time the business associate is responsible for the entry and transmission of OASIS data for Addus Healthcare (Indiana), Inc. Administrator/Agency Director shall ensure that any future individual(s), who is given access to OASIS data for transmission purposes, shall enter into and be bound by a similar contract prior to any access being given. See Exhibit #G111	

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G0123	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on interview and review of agency documents, the agency failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the organizational chart failed to identify the lines of authority down to the patient level. The administrative document "Organizational Structure Addus Healthcare" dated February 2012 was a corporate map and did not include a clear line of authority for the agency. 2. On 12/28/12 at 12 PM, employee A indicated there was no further information available. 	G0123	<p>Policies "Organizational Chart – Addus HomeCare Corporation" 2.6.0, date 5/2011, "Organizational Chart – Agency" 2.6.0A, date 6/8/2011 and "Organizational Chart – Office" 2.6.0B, dated 6/8/2011 and revised 1/3/2013 contain the organizational structure of Addus HomeCare Corporation and Addus Healthcare (Indiana), Inc. and have been revised to show organizational structure to the patient level. All delegation of authority at the facility level is clearly shown on "Organizational Chart – Office" 2.6.0B.</p> <p>Policy "Organizational Plan" 2.7.0, dated 2/9/2010 discusses the responsibilities of the Board of Directors, Professional Advisory Committee, Vice President of the Home Health Division, Director of Clinical Quality Management, Regional Director, Agency Director/Administrator, Director of Patient Care Services (DON), Branch Director (when facilities occupy multiple locations) and the services provided by the Home Health Agency.</p> <p>Addus Healthcare (Indiana), Inc., located in Lafayette, Indiana is the</p>	01/23/2013			

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			Parent Agency and there are no Branch Locations. On 1/23/2013 policy "Organizational Chart – Office" 2.6.0B dated 6/8/2011, revised 1/3/2013 and 1/23/2013 now titled "Addus Healthcare (Indiana), Inc., Lafayette, Indiana (Parent Agency)" was revised to clearly show the Agencies organizational chart and to eliminated ambiguities as to whether there existed branch locations or that the agency was a branch location of another entity. See exhibit #G123A		

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G0135	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities.</p> <p>Based on document review and interview, the administrator failed to ensure its Patient Admission Informational Brochure was accurate for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The undated agency admission brochure evidenced the agency provided rehabilitation, speech language pathologists, physical and occupational therapists, and medical social workers. 2. On 12/27/12 at 1:10 PM, the administrator / director of nursing indicated the agency did not provide therapy and social worker services since they discharged all their Medicare patients in February 2012. 3. On 12/28/12 at 4 PM, the administrator indicated the information within the admission packet was incorrect. 	G0135	<p>The Administrator/ Agency Director will provide to the clinical support coordinator instruction on how to correct the Patient Information Booklet. The Administrator/Agency Director will delegate to the Clinical Support Coordinator the task of correcting the Patient Information Booklets. The section on page three entitled "Rehabilitation" will be removed. The section of page three entitled "Medical Social Services" will be removed. Administrator/Agency Director will inform Addus HomeCare Corporation printing department of the changes so that they are reflected in future print runs. These corrected Patient Information Booklets have been included with the in-servicing on 1/3/2013 and presented in conjunction with policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011. On 1/25/2013 Administrator/Agency Director completed a letter to ISDH informing them of the change in service offerings. Administrator/ Agency Director will review, by 2/5/2013, other agency collateral and printed materials to ensure that unavailable services are not</p>	02/05/2013	

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			advertised. See exhibit #G135 See exhibit #G135A		

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G0141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on personnel file and policy and procedure review and interview, the agency failed to ensure personnel policies for physical examinations and TB screenings were followed for 7 of 7 files of direct care staff (A, C, D, E, F, G, and H) files reviewed of employees who had direct patient with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>Related to physical exam:</p> <ol style="list-style-type: none"> Personnel record A, a registered nurse, date of hire 3/19/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. Personnel record C, a registered nurse, date of hire 7/5/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. 	G0141	<p>All staff were provided information on policy "Employment Health Requirements" 9.2.0, dated 6/13/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation.</p> <p>Staff has been instructed to provide proof of Health Assessment/Physical Exam dated no sooner than 180 days prior to their date of first patient contact. Each employee was provided a standardized form to be completed and signed by their physician, which states that they able to perform patient care and do not pose a direct threat to the health and safety of themselves or others, that they are physically well and free of communicable disease.</p> <p>They must provide TB screening per policy 9.2.0 and state regulation, having record of (2) Mantoux skin tests in the previous 1 year and be tested annually thereafter or chest x-ray if there is documented history of a positive Mantoux test and must sign an attestation on the "Tuberculosis Screening Questionnaire"</p>	02/05/2013			

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	<p>3. Personnel file D, a registered nurse, date of hire 10/2/11, failed to evidence a physical examination of sufficient scope to determine the individual was free from communicable disease.</p> <p>4. Personnel record E, a home health aide, date of hire and first patient contact 9/26/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 10/26/12.</p> <p>5. Personnel record F, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease.</p> <p>6. Personnel record G, a home health aide, date of hire 8/3/12 and first patient contact 8/23/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 8/31/12.</p>		<p>identifying that the applicant is free from signs and symptoms of tuberculosis.</p> <p>Employees must accept or decline Hepatitis B Vaccine.</p> <p>All staff providing direct patient contact must provide this current documentation and confidential personnel health records must contain copies. Personnel health records shall be created and contained separate and confidential from other personnel files and be secured from all staff besides Administrator/Agency Director and Director of Nursing.</p> <p>The Administrator/Agency Director will review 100%, of the current personnel records, by 2/5/2013, to ensure that all records are within compliance. Thereafter this will be done on a quarterly basis until 100% compliance is achieved, and then the audits will be performed annually. Future applicants will be offered conditional employment and will not be allowed to perform any duties until all health requirements have been met.</p> <p>See exhibit #G141</p>				

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	<p>7. Personnel record H, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 12/17/12.</p> <p>8. On 12/28/12 at 2:22 PM, the administrator / director of nursing indicated there was not any further information available.</p> <p>9. The policy titled "Employment Health Requirements - Employee Providing Patient Care" states, "The agency requires that all employees with direct patient contact adhere to state requirements of employee health to ensure that the employee is physically and medically able to perform their assigned duties and that the employee has no health condition that would create a hazard to patients or themselves."</p> <p>Related to TB screening:</p> <p>1. Personnel record A, date of hire 3/19/12, failed to evidence a negative tuberculosis screening within the previous 12 months or a two step PPD had been administered.</p>			

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	<p>2. Personnel record E, a home health aide, date of hire and first patient contact 9/26/12, failed to evidence two or more negative tuberculosis screening within the previous 12 months. The file evidenced a Mantoux dated 10/26/11.</p> <p>3. Personnel record F, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence a negative tuberculosis screening within the previous 12 months or that a two step PPD had been administered.</p> <p>4. Personnel record H, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence a negative tuberculosis screening within the previous 12 months or that a two step PPD had been administered.</p> <p>5. The policy titled "Employment Health Requirements - Employee Providing Patient Care" states, "The agency requires that all employees with direct patient contact adhere to state requirements of employee health to ensure that the employee is physically and medically able to perform their assigned duties and that the employee has no health condition that would create a hazard to patients or themselves. All applicants</p>			

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	<p>whose ... offer of employment of employment requires or may require them to provide patient care must submit the following evidence that they do not have infectious tuberculosis ... Tuberculosis - Mantoux Skin Testing ... The Mantoux skin test can be waived if the applicant can provide results of two or more negative Mantoux skin tests results within one year before employment with the most recent Mantoux skin test read within ninety (90) days before the date of offer of employment."</p> <p>6. On 12/28/12 at 2:22 PM, the administrator / director of nursing indicated there was not any further information available.</p>				

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G0143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record review and interview, the agency failed to ensure the personnel furnishing services implemented effective communication to promote the objectives identified in the plan of care for 1 of 13 records reviewed with the potential to affect all the patients of the agency (Clinical record #8).</p> <p>Findings include:</p>	G0143	<p>The Field Clinicians were In-serviced on the policy "Patient Plan of Care", 4.4.0 dated 6/7/11 on 1/3/2013 and specific attention was given to section 5, under the subheading "policy" which states "the plan of care should be developed, implemented and revised in coordination with the patient, the physician and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice. Field clinicians will adhere to the requirement, under subheading "procedure" #4, which states that "the plan of care and revisions should be communicated effectively to the patient, physician and any other members of the health care team." Failure to do so will result in disciplinary action.</p> <p>The Performance Improvement Coordinator will review 25% of the medical records to ensure that all problems, precautions or contraindications have been effectively communicated to the interdisciplinary team, have been included in the Plan of Care (HCFA-485) and included on the Home Health Aide/Homemaker Care Plan, under the section</p>	01/03/2013	

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	<p>1. Clinical record #8, start of care 12/4/12, evidenced the patient was receiving dialysis on Tuesday and Thursday and the aide was providing a bath for the patient. The record failed evidence the nurse had communicated to the aide, who was bathing the patient, about the fistula, risks and precautions during care.</p> <p>2. On 12/31/12 at 2:20 PM, Employee A, the director of nursing, indicated the patient had a right arm fistula for dialysis and that coordination of care had not occurred between the aide and skilled nurse.</p>		<p>"Special Instructions/Safety Precautions", if applicable. A copy of these documents will be placed in the patient record, in the patient's home and provided to each applicable team member. This will be done on a monthly basis until 100% compliance is achieved, and then the audits will be performed quarterly.</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. Based on clinical record review and interview, the agency failed to ensure coordination of care occurred with other entities providing services for 2 of 2 (# 1 and 9) records reviewed of patients receiving services from other entities with the potential to affect all patients receiving services from another entity.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record # 1, start of care 9/18/12, failed to evidence coordination of care with the other providers of care. <p>On 12/31/12 at 8:30 AM during a home visit, the patient's neighbor was observed to administer the patient's medications and employee G indicated the patient had another agency in the home through 12/30/12 for aide services for 12 hours a day, 7 days a week.</p> <ol style="list-style-type: none"> Clinical record 9, start of care 8/24/12, included a comprehensive assessment that documented the patient diagnoses of paraplegia, chairfast, and a stage four pressure ulcer at the sacral / coccyx area. The record did not evidence coordination 	G0144	<p>All Field Clinicians and Administrative staff were in-serviced on policy "Coordination of Services" 4.5.0, dated 4/18/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation which will be documented in their orientation check list.</p> <p>The primary nurse is responsible for the coordination of services to assigned patients and for the ongoing evaluation of the patient's needs. This will begin with the admission process and be documented on the plan of care, be ongoing, both formal and spontaneous and will be documented in a timely basis. Coordination of care will be documented in the clinical record on the "visit note" or on a case conference/case management note. Updates will be included on the "60 day summary note" and be provided to the physician as required every 60 days.</p> <p>The Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance and then the audits will be performed quarterly.</p>	01/03/2013			

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	<p>of care with any caregivers.</p> <p>On 12/31/12 at 1 PM, employee A indicated the patient received homemaking services through a personal care service 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 policy review and interview, the agency failed to ensure a written summary was sent to the physician every 60 days in 5 of 5 records reviewed of patients receiving care longer than 60 days with the potential to affect all the agency's patients receiving services longer than 60 days. (1, 3, 9, 10, and 12)</p> <p>The findings include;</p> <ol style="list-style-type: none"> Clinical record 1, start of care 9/18/12, failed to evidence a 60 day summary was sent to the attending physician. <p>On 12/31/12 at 1:40 PM, employee A indicated the 60 day summaries were to be written on the OASIS recertification document and that the OASIS data was sent to the physician.</p> <ol style="list-style-type: none"> Clinical record 9, start of care 8/24/12, failed to evidence a 60 day summary was sent to the attending physician. Clinical record 10, start of care 8/21/12, failed to evidence a 60 day summary was sent to the attending physician. 	G0145	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed recertification packets submitted by the field clinicians for the inclusion of the 60 day summary, and delegate the responsibility to the Clinical Support Coordinator to fax the 60 day summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3 rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time.</p> <p>The Performance Improvement Coordinator or Designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is</p>	01/03/2013	

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	<p>4. The undated policy titled "Clinical Record Content and Maintenance" and states, "The client's clinical record will contain ... Copies of Sixty (60) day Summary."</p> <p>5. The policy titled "Coordination of Services" dated 4/18/11 stated, "A summary of services report of pertinent facts from the clinical and progress notes is sent to the patient's attending physician every 60 sixty (60) to sixty - two (62) days."</p> <p>6. The policy dated 5/4/11 titled "Clinical records" stated, "The home health clinical records contain the following: ... Written summary reports are sent to the patient's physician every 60 days - these may be sent every 62 days on non-OASIS patients where allowed by state regulation."</p> <p>7. On 12/31/12 at 1:40 PM, employee A indicated the 60 day summaries were to be written within the electronic OASIS recertification information and that the recertification, including the OASIS data, was to be printed and sent to the physician.</p> <p>8. Clinical record #3, start of care (SOC) 7/20/12, failed to evidence the 60 day summary had been completed for the certification periods of 11/17/12 - 1/15/12</p>		<p>achieved. Then the audits will be performed quarterly.</p> <p>See exhibit #G145</p>		

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	and 9/18/12 - 11/16/12. 9. Clinical record #12, SOC 10/8/12, failed to evidence the 60 day summary had been completed for the certification periods of 10/8/12 - 12/6/12 and 12/7/12 - 2/5/12.				

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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 document review, policy review, and interview, the agency failed to ensure a professional advisory group had met annually to review agency policies for admission and discharge, medical supervision and plans of care, emergency care, clinical records, qualifications, and program evaluation for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence minutes for meetings of the professional advisory committee that identified the group had met to review the agency policies. 2. The policy titled "Professional Advisory Committee (PAC)" dated 4/12/11 states, "The Professional Advisory Committee (PAC) will establish 	G0153	<p>The Administrator/ Agency Director provided exhibit #G153 on January 27 th , 2012 entitled 2011 PAC meeting which contained a member sign in sheet, dated 12/21/2011 and 2011 annual evaluation. Administrator/Agency Director, per policy 1.4.0, learned that the members appointed by the previous Administrator/Agency Director and the Board of Directors do not provide for the best constitution of the Professional Advisory Committee since the agency had changed locations in June 2012. The Administrator/Agency Director will recruit and put into place a new PAC Committee who will represent the current employees and community members. PAC meetings will be held in accordance with policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, the opening meeting being held on or before 2/5/2013. The Administrator/Agency</p>	02/05/2013	

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	<p>and annually review the agencies policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations and provide medical supervision and consultation to the agency."</p> <p>3. On 12/27/12 at 4 PM, the administrator indicated the minutes for the PAC and governing body are maintained in the Addus corporate office in Olympia Fields, Illinois, and he was not provided any further information than what was provided and reviewed.</p>		<p>Director or designee will maintain written minutes of the meetings and related information, which shall be kept at the local office. The Administrator/Agency Director or designee will request the Committee to approve minutes from the previous meeting and the acting Secretary will document said approval. Administrator/Agency Director shall ensure that policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, shall always be followed in the future.</p> <p>See exhibit #G153</p>		

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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 document and policy review and interview, the agency failed to ensure the group of professional personnel met frequently for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence minutes for meetings of the professional advisory committee. 2. The policy titled "Professional Advisory Committee (PAC)" dated 4/12/11 and states, "To advise the organization on professional issues, to participate in the evaluation of the agency's programs, and to assist the organization in maintaining liaison with other healthcare providers in the community. ... Dated minutes are maintained on file in the agency's administrator's office. The agency administrator will establish the meeting dates and time in consultation with 	G0154	<p>The Administrator/ Agency Director provided exhibit #G153 on January 27 th , 2012 entitled 2011 PAC meeting which contained a member sign in sheet, dated 12/21/2011 and 2011 annual evaluation. Administrator/Agency Director, per policy 1.4.0, learned that the members appointed by the previous Administrator/Agency Director and the Board of Directors do not provide for the best constitution of the Professional Advisory Committee since the agency had changed locations in June 2012. The Administrator/Agency Director will recruit and put into place a new PAC Committee who will represent the current employees and community members. PAC meetings will be held in accordance with policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, the opening meeting being held on or before 2/5/2013. The Administrator/Agency Director or designee will maintain written minutes of the meetings and related information, which shall</p>	02/05/2013			

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	<p>members. The Professional Advisory Committee (PAC) will establish and annually review the agencies policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations and provide medical supervision and consultation to the agency."</p> <p>3. On 12/28/12 at 1:15 PM, the administrator indicated meeting minutes for the governing body were maintained in the corporate office in Olympia Fields, Illinois, and he was not provided any further information.</p>		<p>be kept at the local office. The Administrator/Agency Director or designee will request the Committee to approve minutes from the previous meeting and the acting Secretary will document said approval. Administrator/Agency Director shall ensure that policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, shall always be followed in the future. See exhibit #G153</p>		

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G0155	<p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's meetings are documented by dated minutes. Based on document review and interview, the agency failed to ensure the group of professional personnel met frequently and meetings were documented by dated minutes for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence any minutes for meetings of the professional advisory committee. 2. The policy titled "Professional Advisory Committee (PAC)" dated 4/12/11 and states, "To advise the organization on professional issues, to participate in the evaluation of the agency's programs, and to assist the organization in maintaining liaison with other healthcare providers in the community. ... Dated minutes are maintained on file in the agency's administrator's office. The agency administrator will establish the meeting dates and time in consultation with members. The Professional Advisory Committee (PAC) will establish and annually review the agencies policies governing the scope of services offered, 	G0155	<p>The Administrator/ Agency Director provided exhibit #G153 on January 27 th , 2012 entitled 2011 PAC meeting which contained a member sign in sheet, dated 12/21/2011 and 2011 annual evaluation. Administrator/Agency Director, per policy 1.4.0, learned that the members appointed by the previous Administrator/Agency Director and the Board of Directors do not provide for the best constitution of the Professional Advisory Committee since the agency had changed locations in June 2012. The Administrator/Agency Director will recruit and put into place a new PAC Committee who will represent the current employees and community members. PAC meetings will be held in accordance with policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, the opening meeting being held on or before 2/5/2013. The Administrator/Agency Director or designee will maintain written minutes of the meetings and related information, which shall be kept at the local office. The Administrator/Agency Director or designee will request the Committee to approve minutes from the previous meeting and the acting Secretary will</p>	02/05/2013			

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	<p>admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations and provide medical supervision and consultation to the agency."</p> <p>3. On 12/28/12 at 1:15 PM, the administrator indicated any meeting minutes available were maintained in the corporate office in Olympia Fields, Illinois, and he was not provided any further information.</p>		<p>document said approval. Administrator/Agency Director shall ensure that policy "Professional Advisory Committee (PAC)" 1.4.0, dated 4/12/2011, shall always be followed in the future. See exhibit #G153</p>		

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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. Based on clinical record and policy review and interview, the agency failed to ensure the visits and treatments were made as ordered on the plan of care and care was provided only as ordered on the plan of care in 9 of 13 records reviewed (# 1, 3, 4, 5, 6, 8, 10, 11, and 12) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 9/18/12, included documentation employee E provided aide services on November 18, 23, and 24; employee G provided aide services on November 16, 19, 20, 21, 26, 27. 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012; employee I provided aide services on December 1, 2, 8, 9, and 15, 2012; and employee J provided services on November 19, 2012. The clinical record failed to evidence a plan of care or verbal orders for the services provided by the agency.</p> <p>On 12/27/12 at 2:55 PM, employee A</p>	G0158	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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. Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will obtain all orders necessary to provide any care that will be provided by agency personnel. Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments,</p>	02/05/2013			

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	<p>indicated the clinical record did not contain a plan of care for the services provided after November 16, 2012.</p> <p>2. Clinical record 4, start of care 11/14/12, evidenced a physician order dated 11/18/12 for one skilled nurse visit every other week for 5 weeks and to obtain a complete blood count, comprehensive metabolic panel, and a prothrombin time every 2 weeks until otherwise ordered.</p> <p>A. The clinical record evidenced 2 skilled nurse visits only, one dated 11/14/12, the date of the start of care, and the second visit was dated 11/29/12. The record failed to evidence why no further visits were provided.</p> <p>B. On 12/28/12 at 4:38 PM, employee A indicated the patient was discharged on 12/28/12 due to employee C being unable to locate the patient and the documentation should be in the clinical record.</p> <p>3. Clinical record 5, start of care 11/16/12, included a plan of care for the certification period 11/16/12 through 1/14/12 with orders for skilled nursing once a month and aide visits 3 times a week. The record evidenced only 2 visits were provided during week 4 on 12/5 and</p>		<p>interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action.</p> <p>Clinical Support Coordinators were also in-serviced by the Administrator/Agency Director on policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders.</p> <p>Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support</p>				

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	<p>12/7/12 and 2 visits were provided during week 5 on 12/10/12 and 12/12/12. The clinical record failed to evidence why the visits were not made.</p> <p>4. Clinical record # 10, start of care 8/21/12, evidenced a plan of care dated 10/20/12 with orders for aide services 2 times a week for eight weeks. The record evidenced aide services were provided on October 23, 26 and 29 and November 16, 19, 23, and 26, 2012. The record failed to evidence any services were provided between October 29, 2012 and November 16, 2012. The record failed to evidence why the visits were not made.</p> <p>5. Clinical record 11, start of care 9/4/12, included a plan of care for the certification period 9/4/12 through 11/2/12 for aide services two times a week for one week and three times a week for eight weeks and skilled nurse visits one time a month for 3 months. The record failed to evidence any aide services were provided during week one; only two visits were provided during week four, on 9/26/12 and 9/28/12; and two visits were provided during week six on 10/8/12 and 10/10/12. The record failed to evidence why aide services were not provided as ordered.</p> <p>On 12/31/12 at 4:24 PM, employee A</p>		<p>Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director.</p> <p>Effective 1/22/2013, Clinical Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken.</p> <p>An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly.</p> <p>See exhibit #G159</p>		

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	<p>indicated there was no documentation to explain why the visits were not made.</p> <p>6. The policy titled "Physician's Plan of Care / Treatment and Notification of Patient's Change in Condition" dated 4/18/11 and stated, "Home health services should be provided in accordance with an individualized plan of care. ... Modifications / additions to the plan of care / plan of treatment must be approved by the attending physician. Physician will be notified of unforeseen missed visits. ... The plan of care / plan of treatment should include; ... Specific treatments and modalities for each discipline including amount frequency and duration."</p> <p>7. Clinical record #3, start of care (SOC) 7/20/12, included a plan of care (POC) for the certification period of 11/17/12 - 1/15/12 with orders that stated, "Nursing to maintain and change suprapubic catheter every three weeks and prn [as needed] q [every] week with 16 fr [french] 5 cc [cubic centimeter] catheter."</p> <p>a. The clinical record document titled "Nurse Visit Note" signed by Employee C, RN, on 11/26/12, stated, under Skilled Interventions, "Catheter change 22 French 10 cc [cubic centimeter] ... intact and draining."</p>			

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	<p>b. The "Nurse Visit Note" signed by Employee C on 12/24/12 stated, under Skilled Interventions, "Catheter change ... instilled 22 French 10 cc [cubic centimeter] balloon inflated with 10 cc intact draining flushed with 120 cc normal saline." The POC failed to evidence an order for the catheter to be flushed.</p> <p>c. On 12/28/12 at 4:45 PM, Employee A, the director of nursing, indicated the RN did not follow the POC.</p> <p>8. Clinical record #6, SOC 12/6/12, failed to evidence a POC. A skilled nurse visit occurred on 12/6/12. Aide visits occurred on 12/11/12 and 12/13/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was no written POC in this record.</p> <p>9. Clinical record #8, SOC 12/4/12, failed to evidence a POC. The records evidenced a skilled nurse visit occurred on 12/4/12 and Aide visits occurred on 12/6/12, 12/11/12, 12/13/12, and 12/14/12.</p> <p>On 12/31/12 at 2 PM, Employee A indicated the written POC was not in the record.</p>			

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	<p>10. Clinical record #12, SOC 10/8/12, included a plan of care for the certification period of 10/8/12 - 12/6/12 that stated, "Aide 5 [times a] week [for] 9 [weeks]... SN [skilled nurse] 3 [times a] week 9 ... SN to supervise HHA [home health aide] 2 x month."</p> <p>a. The clinical record evidenced nurse visits on 10/10/12, 10/11/12, 10/22/12, 10/24/12, 10/29/12, 11/2/12, and 11/5/12 and "physician notice of visit frequency" (physician notice of missed skilled nurse visits) on 10/12/12, 10/20/12, 10/31/12, 11/7/12, 11/10/12. There were no more skilled nurse visits or missed skilled nurse visit notices noted after 11/10/12 until 12/6/12. There was no supervisory note from a skilled nurse in this time frame either.</p> <p>b. The clinical record evidenced aide visits on 10/8/12, 10/9/12, 10/10/12, 10/11/12, 10/12/12, 10/15/12, 10/16/12, 10/17/12, 10/19/12, 10/22/12, 10/23/12, 10/24/12, 10/25/12, 10/26/12, 11/6/12, 11/8/12, 11/9/12, 11/14/12, 11/15/12, 11/16/12, 11/21/12, 11/23/12, 11/28/12, 11/29/12, 11/30/12, 12/4/12, 12/5/12, and 12/6/12. No visits occurred the week of 10/28/12 - 11/3/12. Visits were reduced to two or three times a week after 11/4/12 for the rest of the certification period with</p>						

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	no update to the plan of care. c. On 12/31/12 at 4:40 PM, Employee A indicated care did not follow the written plan of care.				

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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 policy review and interview, the agency failed to ensure the plans of care included all the required elements for 5 of 13 (records 1, 2, 6, 8, and 11) clinical record reviewed, creating the potential for omission of care and to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 9/18/12, included documentation employee E provided aide services on November 18, 23, and 24; employee G provided aide services on November 16, 19, 20, 21, 26, 27. 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012; employee I provided aide services on December 1, 2, 8, 9, and 15, 2012; and employee J provided services on November 19, 2012. The clinical record failed to evidence a plan of care or verbal orders for the services provided by the</p>	G0159	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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>Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will obtain all orders necessary to provide any care that will be provided by agency personnel.</p>	02/05/2013
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	<p>agency.</p> <p>On 12/27/12 at 2:55 PM, employee A indicated the clinical record did not contain a plan of care for the services provided after November 16, 2012.</p> <p>2. Clinical record # 2, start of care 11/15/12, evidenced documentation that employee F provided aide services on November 19 and 20, 2012 which lasted for 4 hours each; aide services on November 21, 22, 23, 26, and 27, 2012 which lasted for 5.5 hours; on November 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012 the aide visits lasted 6 hours each. The plan of care for the certification period 11/15/12 through 1/13/12 failed to evidence an order for the frequency of the visits to be provided.</p> <p>On 12/28/12 at 4:25 PM, employee A indicated the record did not contain an order for the frequency of the aide visits.</p> <p>3. Clinical record 11, start of care 9/4/12, evidenced a skilled nurse note and comprehensive assessment dated 12/10/12 by employee C and aide services were provided by employee I on 12/11/12. The record failed to evidence an order for the visits on 12/10/12 and 12/11/12.</p> <p>On 12/31/12 at 4 PM, employee A</p>		<p>Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments, interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action.</p> <p>Clinical Support Coordinators were also in-serviced by the Administrator/Agency Director on policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders.</p> <p>Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency</p>		

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	indicated the agency was not able to obtain physician signature for the orders received and was informed by the veteran's administration that the patient should not have been discharged on 11/2/12.		<p>will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director.</p> <p>Effective 1/22/2013, Clinical Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken.</p> <p>An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance.</p>		

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	<p>4. Clinical record #6, SOC 12/6/12, failed to evidence a plan of care (POC). A skilled nurse visit occurred on 12/6/12. Aide visits occurred on 12/11/12 and 12/13/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was not a POC in the record.</p> <p>5. Clinical record #8, SOC 12/4/12, failed to evidence POC. A skilled nurse visit occurred on 12/4/12. Aide visits occurred on 12/6/12, 12/11/12, 12/13/12, and 12/14/12.</p> <p>On 12/31/12 at 2 PM, Employee A indicated the POC was not in the record.</p>		<p>This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly.</p> <p>See exhibit #G159</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 review and interview, the agency failed to ensure the registered nurse provided services as ordered in accordance with the plan of care for 4 of 13 records reviewed with the potential to affect all the agency's current patients. (# 3, 6, 8, and 12)</p> <p>The findings include:</p>	G0170	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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.Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will obtain all orders necessary to provide any care that will be provided by agency personnel.</p>	02/05/2013

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			Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments, interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/- or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action. Clinical Support Coordinators were also in-serviced by the Administrator/Agency Director on policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing	

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			documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders. Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director. Effective 1/22/2013, Clinical Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to	

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	1. Clinical record #3, start of care (SOC) 7/20/12, included a plan of care (POC) for the certification period of 11/17/12 - 1/15/12 with orders that stated, "Nursing to maintain and change suprapubic catheter every three weeks and prn [as needed] q [every] week with 16 fr [french] 5 cc [cubic centimeter] catheter."		ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken. An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly. See exhibit #G159		

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	<p>a. The clinical record document titled "Nurse Visit Note" signed by Employee C, RN, on 11/26/12, stated, under Skilled Interventions, "Catheter change 22 French 10 cc [cubic centimeter] ... intact and draining."</p> <p>b. The "Nurse Visit Note" signed by Employee C on 12/24/12 stated, under Skilled Interventions, "Catheter change ... instilled 22 French 10 cc [cubic centimeter] balloon inflated with 10 cc intact draining flushed with 120 cc normal saline." The POC failed to evidence an order for the catheter to be flushed.</p> <p>c. On 12/28/12 at 4:45 PM, Employee A, the director of nursing, indicated the RN did not follow the POC.</p> <p>2. Clinical record #6, SOC 12/6/12, failed to evidence a POC. A skilled nurse visit occurred on 12/6/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was no written POC in this record.</p> <p>3. Clinical record #8, SOC 12/4/12, failed to evidence a POC. The records evidenced a skilled nurse visit occurred on 12/4/12.</p>			

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	<p>On 12/31/12 at 2 PM, Employee A indicated the POC was not in the record.</p> <p>4. Clinical record #12, SOC 10/8/12, included a plan of care for the certification period of 10/8/12 - 12/6/12 that stated, "Aide 5 [times a] week [for] 9 [weeks]... SN [skilled nurse] 3 [times a] week 9 ... SN to supervise HHA [home health aide] 2 x month."</p> <p>a. The clinical record evidenced nurse visits on 10/10/12, 10/11/12, 10/22/12, 10/24/12, 10/29/12, 11/2/12, and 11/5/12 and "physician notice of visit frequency" (physician notice of missed skilled nurse visits) on 10/12/12, 10/20/12, 10/31/12, 11/7/12, 11/10/12. There were no more skilled nurse visits or missed skilled nurse visit notices noted after 11/10/12 until 12/6/12. There was no supervisory note from a skilled nurse in this time frame either.</p> <p>b. On 12/31/12 at 4:40 PM, Employee A indicated care did not follow the written plan of care.</p>						

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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 policy review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral as required by agency policy in 2 of 13 clinical records reviewed with the potential to affect all new patients. (# 12 and 13)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 13, start of care 11/1/12, evidenced a verbal order dated 10/29/12 to provide skilled nurse services once a week to address diagnosis hypertension and pulmonary disease. The record failed to evidence an initial assessment was completed within 48 hours of the referral or documentation to explain why the initial visit was late. 2. The policy titled "Evaluation / Admission Process" dated 4/14/11 stated, "The RN or therapist should contact the patient / and or caregivers to make arrangements for an evaluation visit. The evaluation visit should be scheduled within forty - eight (48) hours of referral." 	G0171	<p>All Field Clinicians and Administrative staff were in-serviced on policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation.</p> <p>Referral can be initiated by any staff member and should be documented on exhibit #G171 "Skilled Client Referral". Once the referral process has been initiated, the Clinical Support Coordinators will gather additional information needed such as client demographics, payor information, and clinical information. This will be provided to the appropriate RN who will, within 48hrs of referral or hospital discharge, schedule an evaluation and possible initial assessment or document why assessment/care could not be initiated.</p> <p>The Performance Improvement Coordinator and/or designee will review 100% of the referral records on a monthly basis to ensure compliance. When 100% compliance has been achieved the audits will be performed on a quarterly basis. 100% of all new referral records will continue to be reviewed. The Administrator is responsible for monitoring the</p>	01/03/2013

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	<p>3. Clinical record #12, start of care 10/8/12, evidenced a referral to home care dated 9/13/12 and a comprehensive assessment on 10/11/12. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs.</p> <p>On 12/31/12 at 5:08 PM, the director of nursing indicated the initial assessment had not been completed in 48 hours.</p>		<p>Performance Improvement Coordinator and ensuring that reviews are completed.</p> <p>See exhibit #G171</p>		

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES Based on personnel record, clinical record, and policy review and interview, it was determined the agency failed to ensure the home health aide successfully completed a competency evaluation program before the aide provided care for 4 of 4 aides employed by the agency (See G 211), failed to ensure the home health aide met the competency evaluation requirement for 4 of 4 aides employed by the agency (See G 212), failed to ensure the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care for 4 of 4 aides employed by the agency (See G 213), failed to ensure the home health aide successfully completed a competency evaluation program performed by a registered nurse for 1 of 4 aides employed by the agency (See G 217), failed to ensure the home health aide successfully completed a competency evaluation program was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section for 4 of 4 aides employed by the agency (See G 218), failed to ensure</p>	G0202	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the</p>	02/05/2013			

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	<p>documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care for 4 of 4 aides employed by the agency (See G 221), failed to ensure the registered nurse provided care instructions for the home health aide for 1 of 2 home visits conducted with orders for a home health aide (See G 224), and failed to ensure the registered nurse conducted a supervisory visit at least every 14 days for 4 of 9 clinical records reviewed with orders for skilled and aide services for a minimum of 14 days with the potential to affect all patients receiving aide services (See G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to ensure safe home health aide care was provided as required by the Condition of Participation 484.36: Home Health Aide services.</p>		<p>aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home</p>		

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			Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.		

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G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>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, clinical record, and policy review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation program before the aide provided care for 4 of 4 aide files reviewed of aides employed by the agency with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <p>1. Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse.</p> <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on November, 18, 23, and 24, 2012.</p>	G0211	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed</p>	02/05/2013			

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	<p>2. Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in</p>		<p>at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home</p>				

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	<p>body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that was painful, and the patient had little use of the extremity. The caregiver indicated</p>		<p>Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>		

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	<p>employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to</p>						

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	complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."			

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NAME OF PROVIDER OR SUPPLIER ADDUS HEALTHCARE (INDIANA) INC				STREET ADDRESS, CITY, STATE, ZIP CODE 674 N 36TH ST LAFAYETTE, IN 47905			
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G0212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on personnel record, clinical record, and policy review and interview, the agency failed to ensure the home health aide met the competency evaluation requirement for 4 of 4 aides employed by the agency with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse. <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on November, 18, 23, and 24, 2012.</p> <ol style="list-style-type: none"> Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / 	G0212	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x),</p>	02/05/2013			

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	<p>Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency</p>		<p>and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and</p>		

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	<p>procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H</p>		<p>Competency and ensure that Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>				

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	<p>indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of</p>				

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	personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."			

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G0213	<p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>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 record clinical record, and policy review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care for 4 of 4 aides employed by the agency with the potential to affect all the patients receiving home health aide services with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse. <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on</p>	G0213	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section,</p>	02/05/2013			

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	<p>November, 18, 23, and 24, 2012.</p> <p>2. Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions,</p>		<p>documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that</p>				

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	<p>basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that</p>		Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.				

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	<p>was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations.</p>						

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	<p>Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."</p>			

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G0217	<p>484.36(b)(3)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care.</p> <p>Based on personnel record and clinical record review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation program performed by a registered nurse for 1 of 4 aides employed by the agency with the potential to affect all the patients receiving home health aide services. (E)</p> <p>The findings include:</p> <p>1. Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse.</p> <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on November, 18, 23, and 24, 2012.</p>	G0217	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was</p>	02/05/2013	

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	<p>2. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware of all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>3. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 and stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral</p>		<p>completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only.</p> <p>On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information.</p> <p>Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and</p>		

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	hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."		competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.	

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G0218	<p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on personnel record, clinical record, and policy review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation program was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section for 4 of 4 aides employed by the agency with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <p>1. Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a</p>	G0218	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was</p>	02/05/2013			

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	<p>registered nurse.</p> <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on November, 18, 23, and 24, 2012.</p> <p>2. Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency</p>		<p>performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7th, 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or</p>		

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	<p>and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate</p>		<p>competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>	

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	<p>nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide</p>						

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	<p>Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."</p>				

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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 record, clinical record, and policy review and interview, the agency failed to ensure documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care for 4 of 4 aides employed by the agency with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse. <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on November, 18, 23, and 24, 2012.</p> <ol style="list-style-type: none"> Personnel record F, date of hire and first patient contact 11/15/12, evidenced a 	G0221	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section,</p>	02/05/2013			

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	<p>document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing</p>		<p>documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that</p>		

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	<p>emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation</p>		<p>Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>				

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	<p>occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and</p>			

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	demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."			

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on the clinical record review and interview, the agency failed to ensure the registered nurse provided care instructions for the home health aide for 1 of 2 home visits conducted with orders for a home health aide with the potential to affect all patients who receive home health aide services. (3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During a home visit on 12/31/12 at 10 AM, employee C indicated patient 3 had a dislocation of the right shoulder which was painful and the patient had little use of the extremity. The caregiver indicated the patient received caregivers from the agency every morning for bathing and transfers out of bed and someone from the agency returns 3 evenings a week to return the patient to bed,. All transfers are with the Hoyer lift; the patient is unable to bear weight. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation of the right shoulder occurred about one year ago when the patient fell. 	G0224	<p>The Field Clinicians were In-serviced on the policy "Patient Plan of Care", 4.4.0 dated 6/7/11 on 1/3/2013 and specific attention was given to section 5, under the subheading "policy" which states "the plan of care should be developed, implemented and revised in coordination with the patient, the physician and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice. Field clinicians will adhere to the requirement, under subheading "procedure" #4, which states that "the plan of care and revisions should be communicated effectively to the patient, physician and any other members of the health care team." Failure to do so will result in disciplinary action.</p> <p>The Performance Improvement Coordinator will review 25% of the medical records to ensure that all problems, precautions or contraindications have been effectively communicated to the interdisciplinary team, have been included in the Plan of Care</p>	01/03/2013	

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	<p>Employee H indicated she provided and completed bed baths for patient 3, transferred the patient between surfaces via a Hoyer lift daily, emptied the patient's urinary drainage bag, and demonstrated on herself the patient's ability to raise the right arm was shoulder height.</p> <p>2. Clinical record #3, start of care 7/20/12, with a plan of care for the certification period of 9/18/12 - 11/18/12 failed to evidence an aide care plan with instructions despite aide visits which occurred 5 days per week.</p>		<p>(HCFA-485) and included on the Home Health Aide/Homemaker Care Plan, under the section "Special Instructions/Safety Precautions", if applicable. A copy of these documents will be placed in the patient record, in the patient's home and provided to each applicable team member. Field Clinicians will personally provide these documents to the Home Health Aide and verbally report all "Special Instructions/Safety Precautions". This will be done on a monthly basis until 100% compliance is achieved, and then the audits will be performed quarterly.</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 policy review and interview, the agency failed to ensure the registered nurse conducted a supervisory visit at least every 14 days for 4 of 9 (2, 5, 10, and 12) clinical records reviewed of patients with orders for skilled and aide services for a minimum of 14 days with the potential to affect all patients receiving aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record # 2, start of care 11/15/12, included a plan of care dated 11/15/12 with orders for skilled nursing once a month for 3 months and aide services five times a week for 10 weeks. Documentation evidenced employee F, the home health aide, provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012. The clinical record failed to evidence a supervisory visit was conducted. <p>On 12/28/12 at 4:25 PM, employee A indicated there were not any visit notes that were not filed.</p>	G0229	<p>The Administrator/ Agency Director in-serviced, on 1/3/2013, the Field Clinicians on the requirement of Home Health Aide (HHA) Supervisory visits. Per policy "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, HHA Supervisory visits must be conducted, at a minimum of every 14 days, where skilled care and home health aide services are provided, and every 30 days for patients who receive home health aide services only. Field Clinicians will document these supervisory visits on the "Nursing Visit Note" for skilled visits and hha only visits. In addition field clinicians will also document this visit on the Home Health Aide Supervision Note. The Administrative/Agency Director will review and discuss with all new field clinician employee orientations and document confirmation on the skills checklist.</p> <p>The clinical support coordinator will, on a weekly basis, track Home Health Aide (HHA) supervisory visits utilizing the current calendar tracking form used for monitoring frequencies and durations. Any discrepancies</p>	01/03/2013			

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	<p>2. Clinical record 5, start of care 11/16/12, included a plan of care for the certification period 11/16/12 through 1/14/12 with orders for skilled nursing once a month and aide visits 3 times a week. The clinical record identified aide services were provided on November 16, 18, 19, 21, 23, 26, 28, and 30 and December 5, 7, 10, and 12, 2012 from employees C, H, I, and K. The clinical record failed to evidence a supervisory visit was made. The record evidenced only 2 skilled visits, one dated 11/16/12 and one dated 12/21/12.</p> <p>3. Clinical record # 10, start of care 8/21/12, evidenced a plan of care dated 10/20/12 with orders for skilled nursing once a month and aide services 2 times a week for eight weeks. The record evidenced aide services were provided on October 23, 26 and 29 and November 16, 19, 23, and 26, 2012. The clinical record evidenced a supervisory visit was made on 10/16/12 and 11/29/12.</p> <p>4. The policy titled "Home Health Aide Services" dated 6/7/11 stated, "A registered nurse or therapist a supervisory visit at least every two weeks when skilled services are being provided and every 60 - 62 (sixty - sixty - two) days when no skilled services are ordered, or in</p>		<p>will be reported to the Administrator/Agency Director. Failure to do so will result in disciplinary action.</p> <p>The Administrator/ Agency Director will be responsible for overseeing that the clinical support coordinator performs the above task and will monitor these corrective actions to ensure HHA supervisory visits are timely.</p> <p>The Performance Improvement Coordinator will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved, and then the audits will be performed quarterly.</p> <p>See exhibit #G229</p>				

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	<p>accordance with applicable state regulations or third party payer guidelines."</p> <p>5. Clinical record #12 included physician orders dated 10/8/12 for the skilled nurse to supervise the home health aide two times a month for 9 weeks. The record failed to evidence the registered nurse had made any supervisory visits after 11/10/12, despite aide visits which occurred 11/14/12, 11/15/12, 11/16/12, 11/21/12, 11/23/12, 11/28/12, 11/29/12, 11/30/12, 12/4/12, 12/5/12, and 12/6/12.</p> <p>On 12/31/12 at 4:40 PM, Employee A indicated no RN supervisory visits occurred between 11/10/12 - 12/6/12.</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.</p> <p>Based on clinical record and policy review, the agency failed to ensure a discharge summary was written and the doctor was informed of the availability of such summary for 4 of 4 discharged records reviewed (# 9, 10, 11, and 13) with the potential to affect all patients who are discharged.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 9, start of care 8/24/12 and discharge 11/26/12, failed to evidence a discharge summary or that the physician was informed a discharge summary was available. 2. Clinical record # 10, start of care 8/21/12 and discharge date 12//14/12, failed to evidence a discharge summary or that the physician was informed a discharge summary was available. 3. Clinical record 11, start of care 9/4/12, evidenced a transfer / discharge assessment was completed dated 11/2/12. The record failed to evidence a discharge 	G0303	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed discharge packets submitted by the field clinicians for the inclusion of the discharge summary, and delegate the responsibility to the Clinical Support Coordinator to fax the discharge summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3 rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time.</p> <p>The Performance Improvement Coordinator or Designee will</p>	01/03/2013	

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	<p>summary or that the physician was informed a discharge summary was available.</p> <p>4. Clinical record 13, start of care 11/1/12,evidenced a transfer / discharge assessment was completed dated 11/2/12. The record failed to evidence a discharge summary or that the physician was informed a discharge summary was available.</p> <p>5. The undated policy titled "Clinical Record Content and Maintenance" states, "The client's clinical record will contain ... Discharge Summary."</p>		<p>review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved. Then the audits will be performed quarterly.</p>	

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G0310	<p>484.11 RELEASE OF PATIENT IDENTIFIABLE OASIS INFO The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable information to the public.</p> <p>Based on interview and review of policy, it was determined the agency failed to ensure a written contract was in place with the entity / individual that transmitted the patient identifiable information and OASIS data items to the state agency and a policy was developed and implemented to ensure the confidentiality of all patient identifiable information, including OASIS data items, for 1 of 1 agency reviewed with the potential to affect all current and past patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/27/12 at 1:10 PM, employee A indicated an individual who was not an employee of the agency transmitted all the OASIS assessment items for all agency patients and provided the transmission validation reports to the agency via electronic mail. On 12/27/12 at 3 PM, employee A indicated there was not a written contract 	G0310	Administrator/Agency Director is responsible for maintaining the standard. Per Addus policy, "Oasis – Outcome and Assessment Information Set" 2.14.0, dated 4/14/2011, paragraph 14, under sub heading "procedure", " Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data." An employee of Addus Healthcare, Inc. was responsible for the transmission of locked OASIS assessments, but the employee was not located at the Agency. Administrator/Agency Director provided a copy of the employee's signed job description, outlining her role in OASIS data transmission, her signed HIPAA statement and her non-disclosure agreement. Per 42 CFR 484.11, it was determined that the employee was not a direct employee of the agency and thus required a written contract. On January 7 th , 2013, A HIPAA Business Associate Agreement was	01/07/2013	

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	<p>between the individual responsible for the transmission of the OASIS data items and provision of validation reports to the agency. He indicated the patients were not informed that their information was going to be shared with this individual outside of the agency.</p> <p>3. The policy titled "OASIS - OUTCOME AND ASSESSMENT INFORMATION SET / COMPREHENSIVE ASSESSMENTS" stated, "Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data."</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to ensure patient identifiable information was protected as required by the Condition of Participation 484.11: Release of Patient Identifiable OASIS Information.</p>		<p>mutually executed to address 42 CFR 484.11. According to Article IV "Term and Termination", number 1 "Term", the agreement shall be effective the first day of the Business Associates employment and shall run through the duration of the time the business associate is responsible for the entry and transmission of OASIS data for Addus Healthcare (Indiana), Inc. Administrator/Agency Director shall ensure that any future individual(s), who is given access to OASIS data for transmission purposes, shall enter into and be bound by a similar contract prior to any access being given. See Exhibit #G111</p>		

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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, administrative document, and policy review and interview, the agency failed to ensure the OASIS data was transmitted to the state within 30 days of the M 00090 date (date assessment completed) for 3 of 3 records reviewed that required an assessment to be sent to the state with the potential to affect all the agency's patients that require OASIS items be collected. (#1, 3, and 9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/27/12 at 1:10 PM, employee A indicated an individual, who was not an employee of the agency, was to transmit all the OASIS data and provide the validation reports to the agency. He indicated he became aware in October 2012 that the OASIS data items were not transmitted since the agency relocated to Lafayette. The policy titled "OASIS - OUTCOME AND ASSESSMENT INFORMATION SET / COMPREHENSIVE ASSESSMENTS" stated, "All OASIS data will be locked 	G0321	<p>Administrator/Agency Director provided in-servicing to Field Clinicians and Clinical Support coordinators, on January 3 rd , 2013, concerning policy "Oasis – Outcome and Assessment Information Set/Comprehensive Assessment" dated 4/14/2011. Employees were given time to ask questions and examples of Oasis – Start of Care, Oasis – Resumption of Care, Oasis – Transfers, and Oasis – Discharge forms were provided to staff. Timelines required by the policy and CMS guidelines were discussed and staff signed that they understood the above mentioned policy. The admission/start of care checklist will be used by Field Clinicians, Clinical Support Coordinators, and Administrator/Agency Director to verify completion of OASIS documents. The resumption checklist will be used by Field Clinicians, Clinical Support Coordinators, and Administrator/Agency Director to verify completion of OASIS documents. The transfer checklist will be used by Field Clinicians, Clinical Support Coordinators, and Administrator/Agency Director to verify completion of OASIS documents. The discharge checklist</p>	01/03/2013			

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	<p>and transmitted to the state within the required thirty (30) days following the completion date of the OASIS (M 0090). ... An OASIS validation report will be printed after every transmission to the state agency. These reports will be maintained confidentially in chronological order."</p> <p>3. Clinical record 1, start of care 9/18/12, evinced a recertification assessment with OASIS data items was completed on 11/16/12.</p> <p>On 12/27/12 at 3 PM, employee A indicated the OASIS items collected on 11/16/12 had not been submitted.</p> <p>4. Clinical record 3, start of care 7/20/12, included a recertification assessment with OASIS data items dated on 9/15/12 and 11/16/12 (M 0090 date).</p> <p>The validation report dated 11/27/12 evidenced the 9/15/12 data was submitted and the validation report dated 12/28/12 at 11:16 AM evidenced the data items dated 11/16/12 were submitted and accepted with a +286 warning that the assessment was not submitted within CMS timing guidelines.</p> <p>5. Clinical record 9, start of care 8/24/12, included a recertification with OASIS</p>		<p>will be used by Field Clinicians, Clinical Support Coordinators, and Administrator/Agency Director to verify completion of OASIS documents. The recertification checklist will be used by Field Clinicians, Clinical Support Coordinators, and Administrator/Agency Director to verify completion of OASIS documents.</p> <p>The Administrator/Agency Director or Designee will, using Horizon – Clinical Explorer, daily determine that there are no Oasis documents left uncompleted.</p> <p>The Performance Improvement Coordinator or Designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved. Then the audits will be performed quarterly.</p> <p>See exhibit #G321</p>				

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	<p>data items collected and completed on 10/22/12 (M 0090 date).</p> <p>The validation report dated 11/29/12 evidenced the data was submitted and accepted with a + 286 warning that the assessment was not submitted within CMS timing guidelines.</p>			

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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 policy review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral in 2 of 13 clinical records reviewed with the potential to affect all new patients. (# 12 and 13)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 13, start of care 11/1/12, evidenced a verbal order dated 10/29/12 to provide skilled nurse services once a week to address diagnosis hypertension and pulmonary disease. The record failed to evidence an initial assessment was completed within 48 hours of the referral or documentation to explain why the initial visit was late. 2. The policy titled "Evaluation / Admission Process" dated 4/14/11 stated, "The RN or therapist should contact the patient / and or caregivers to make arrangements for an evaluation visit. The evaluation visit should be scheduled within forty - eight (48) hours of referral." 	G0332	<p>All Field Clinicians and Administrative staff were in-serviced on policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation.</p> <p>Referral can be initiated by any staff member and should be documented on exhibit #G171 "Skilled Client Referral". Once the referral process has been initiated, the Clinical Support Coordinators will gather additional information needed such as client demographics, payor information, and clinical information. This will be provided to the appropriate RN who will, within 48hrs of referral or hospital discharge, schedule an evaluation and possible initial assessment or document why assessment/care could not be initiated.</p> <p>The Performance Improvement Coordinator and/or designee will review 100% of the referral records on a monthly basis to ensure compliance. When 100% compliance has been achieved the audits will be performed on a quarterly basis. 100% of all new referral records will continue to be</p>	01/03/2013

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	<p>3. Clinical record #12, start of care 10/8/12, evidenced a referral to home care dated 9/13/12 and a comprehensive assessment on 10/11/12. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs.</p> <p>On 12/31/12 at 5:08 PM, the director of nursing indicated the initial assessment had not been completed in 48 hours.</p>		<p>reviewed. The Administrator is responsible for monitoring the Performance Improvement Coordinator and ensuring that reviews are completed.</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 policy review and interview, the agency failed to ensure a comprehensive discharge assessment was completed timely for 3 of 5 discharged records reviewed with the potential to affect all the agency's patients who are discharged. (# 4, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record 4, start of care 11/14/12 evidenced 2 skilled nurse visits only and the last was dated 11/29/12. The clinical record evidenced a six page discharge assessment completed on 12/28/12.</p> <p>On 12/28/12 at 4:38 PM, employee A indicated the patient was discharged on 12/28/12 due to employee C unable to locate the patient since 11/29/12 and that documentation of attempts to contact the patient should have been documented in the clinical record.</p> <p>2. Clinical record # 9 evidenced the patient was discharged on 11/26/12. The record failed to evidence a comprehensive discharge assessment had been completed.</p>	G0341	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed discharge packets submitted by the field clinicians for the inclusion of the comprehensive discharge assessment, and delegate the responsibility to the Clinical Support Coordinator to fax the discharge summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3 rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011, "Discharge and Transfer of Patients" 2.13.0, dated 4/13/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time.</p> <p>Field Clinicians will be responsible for obtaining orders to discharge patient and</p>	01/03/2013			

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	<p>3. Clinical record 10, start of care 8/21/12, evidenced the patient was discharged on 12/14/12 due to a hospitalization and last assessed by the registered nurse on 11/29/12. The clinical record evidenced a six page discharge assessment on 12/14/12.</p> <p>4. The policy titled "OASIS - OUTCOME AND ASSESSMENT INFORMATION SET / COMPREHENSIVE ASSESSMENTS" stated, "At discharge ... If the professional is not aware that their last visit, the discharge OASIS will be completed as soon as possible based on the available information."</p>		<p>completing the comprehensive discharge assessment and gathering OASIS discharge information. The policy "OASIS " 2.14.0, dated 4/14/2011 and policy "Discharge and Transfer of Patients" 2.13.0, dated 4/13/2011 were in-serviced by the Administrator/Agency Director to all Field Clinicians and Clinical Support Coordinators on January 3 rd , 2013.</p> <p>The Performance Improvement Coordinator or Designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved. Then the audits will be performed quarterly.</p>		

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N0000	<p>This was a state home health relicensure survey.</p> <p>Facility provider number: 009467</p> <p>Survey dates: December 27, 28, and 31, 2012</p> <p>Medicaid vender number: 200928760FW</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor Ingrid Miller, RN, Public Health Nurse Surveyor</p> <p>Unduplicated admissions: 149</p> <p>Clinical record review: 13 Home Visits: 2</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 7, 2013</p>	N0000					

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N0440	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>Based on interview and review of agency documents, the agency failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the organizational chart failed to identify the lines of authority down to the patient level. The administrative document "Organizational Structure Addus Healthcare" dated February 2012 was a corporate map and did not include a clear line of authority for the agency. 2. On 12/28/12 at 12 PM, employee A indicated there was no further information available. 	N0440	<p>Policies "Organizational Chart – Addus HomeCare Corporation" 2.6.0, date 5/2011, "Organizational Chart – Agency" 2.6.0A, date 6/8/2011 and "Organizational Chart – Office" 2.6.0B, dated 6/8/2011 and revised 1/3/2013 contain the organizational structure of Addus HomeCare Corporation and Addus Healthcare (Indiana), Inc. and have been revised to show organizational structure to the patient level. All delegation of authority at the facility level is clearly shown on "Organizational Chart – Branch" 2.6.0B.</p> <p>Policy "Organizational Plan" 2.7.0, dated 2/9/2010 discusses the responsibilities of the Board of Directors, Professional Advisory Committee, Vice President of the Home Health Division, Director of Clinical Quality Management, Regional Director, Agency Director/Administrator, Director of Patient Care Services (DON), Branch Director (when facilities occupy multiple locations) and the services provided by the Home Health Agency.</p> <p>See exhibit #G123</p>	01/03/2013	

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N0447	<p>410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities.</p> <p>Based on document review and interview, the administrator failed to ensure its Patient Admission Informational brochure was accurate for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The undated agency admission brochure evidenced the agency provided rehabilitation, speech language pathologists, physical and occupational therapists, and medical social workers. 2. On 12/27/12 at 1:10 PM, the administrator / director of nursing indicated the agency did not provide therapy and social worker services since they discharged all their Medicare patients in February 2012. 3. On 12/28/12 at 4 PM, the administrator indicated the information within the admission packet was incorrect. 	N0447	<p>The Administrator/ Agency Director will provide to the clinical support coordinator instruction on how to correct the Patient Information Booklet. The Administrator/Agency Director will delegate to the Clinical Support Coordinator the task of correcting the Patient Information Booklets. The section on page three entitled "Rehabilitation" will be removed. The section of page three entitled "Medical Social Services" will be removed. Administrator/Agency Director will inform Addus HomeCare Corporation printing department of the changes so that they are reflected in future print runs.</p> <p>These corrected Patient Information Booklets have been included with the in-servicing on 1/3/2013 and presented in conjunction with policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011.</p> <p>Administrator/ Agency Director will review, by 2/5/2013, other agency collateral and printed materials to ensure that unavailable services are not</p>	02/05/2013			

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			advertised. See exhibit #G135		

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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 on document review, policy review, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program (QAPI) was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. Administrative documents failed to evidence the agency conducted an ongoing quality improvement program. The information submitted was reviewed. The most recent information was dated May 2010 and titled "Quarterly Multidisciplinary Clinical Record Review." The agency failed to evidence any planning to assess the quality of and</p>	N0456	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review the policy "Performance Improvement Plan" 3.4.0, dated 1/31/2011, and develop a plan to include: Monitoring policies, procedures, and practices to ensure that they provide for a high quality of care and effective operations, Monitor adverse event reports, Utilize OBQI and OBQM, as available, reports to identify performance improvement opportunities, Monitor Patient and physician/referral source satisfaction with services to ensure needs are met, Monitor unusual occurrences and grievances to prevent reoccurrence, Maintain compliance with applicable federal and state regulations, Ensure the accuracy and appropriateness of the plan of care in meeting individualized patient needs, Monitor infection control log, Monitor patient complaints and resolutions,</p>	02/05/2013	

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	<p>to improve patient care.</p> <p>2. On 12/28/2012 at 4 PM, the surveyor requested a copy of the quality insurance performance improvement program (QAPI). The administrator indicated there was no recent documentation and stated, "We are small."</p> <p>3. The policy titled Performance Improvement Plan" dated 11/02/09 and stated, "The Performance Improvement Plan will be reviewed / revised annually. Specific objectives of the plan include: Monitor policies, procedures and practices ... Monitor adverse events reports and address and resolve identified or potential problems ... Monitor patient and physician / referral source satisfaction ... Monitor infection control log and address identified or potential problems."</p>		<p>evaluate patient outcomes, ensure accurate and timely completion and transmission of OASIS assessments, and Ensure timely and accurate billing of services. High risk processes will be monitored to include infectious diseases, wounds, and patient falls.</p> <p>Monitoring and evaluation of the processes will be designed to facilitate systematic, organized problem solving and improvement. Reports of the evaluations will be distributed to the Professional Advisory Committee, corporate management and the governing body for review on an annual or more frequent basis, if indicated.</p> <p>Identification of problems or opportunities for improvement, actions to facilitate improvement will be developed and prioritized by severity. Once areas of improvement have been selected the Administrator/Agency Director; with input from the PAC, management, agency staff and the governing body will develop a systematic plan of implementation of the improvement activity.</p> <p>All agency policies for confidentiality will be followed when conducting QAPI activities. No results which contain patient's identifiable information will be</p>		

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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 record and policy review and interview, the agency failed to ensure personnel records included documentation of orientation to the job for 6 of 7 direct care staff records reviewed (A, D, E, F, G, and H); a signed job description for 6 of 7 direct care staff records reviewed (A, C, D, E, F, and H); a criminal history pursuant to IC 16-27-2 for 5 of 7 direct care staff records reviewed (D, E, F, G, and H); and verification of being on the state aide registry for 3 of 4 aide files reviewed (E, F, and H) with the potential to affect all the agency's patients.</p> <p>Findings include:</p>	N0458	The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review the policies; "General Orientation" 6.1.0, dated 4/18/2011, "In-Service Education" 6.2.0, dated 3/20/2003, "Orientation Program for Rehabilitation Staff" 6.4.0, dated 4/19/2011, "Orientation Program for Office Staff" 6.5.0, dated 4/19/2011, "Orientation Program for Nursing Staff" 6.6.0, dated 6/15/2011 and "Employment Procedures" 9.3.0, dated 6/15/2011 and develop a prospective employee packet to contain information needed dependent on job function. This will include information to instruct employees on their functions within the Agency, compliance	02/05/2013			

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	<p>1. Personnel record A, date of hire 3/5/12, received from Olympia Fields, Illinois, electronically, failed to evidence the individual was oriented to the position of the administrator, director of nursing, and registered nurse and a dated job description for the position of the administrator, director of nursing, and registered nurse.</p> <p>2. Personnel record C, date of hire 7/5/12, failed to evidence the employee had a dated job description for the position of a registered nurse.</p> <p>3. Personnel record D, date of hire 7/5/11, received from Olympia Fields, Illinois, electronically, failed to evidence a dated job description, was oriented to the position as the alternate director of nursing, and a national criminal history pursuant to IC 16-27-2. The file evidenced the individual was a resident of the state of Illinois.</p> <p>4. Personnel record E, date of hire and first patient contact 9/26/12, failed to evidence the employee had been oriented to the position of home health aide, a dated job description, a criminal history background check within 3 days of providing services on behalf of the agency, and documentation the aide was listed on and in good standing on the</p>		<p>with regulations, and the Agency's function in the community. Orientation will instruct employees on the Agency's philosophy, policies and procedures related to their specific responsibilities.</p> <p>All current Field Clinicians and Clinical Support Coordinators will be reviewed and been reoriented as needed to their individual jobs and signed job descriptions, have had a criminal history pursuant to IC 16-27-2 completed, licensure verified with State Agencies and items added that were not correctly filed.</p> <p>The Clinical Support Coordinators may assist as needed with completion of personnel files and instruction on benefits other than insurance benefits and personnel policies, but will always be at the direction and supervision of the Administrator/Agency Director.</p> <p>The Administrator/Agency Director will review 100%, of the current personnel records, by 2/5/2013, to ensure that all records are within compliance. Thereafter this will be done on a quarterly basis until 100% compliance is achieved, and then the audits will be performed annually.</p>				

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	<p>home health aide state registry.</p> <p>5. Personnel record F, date of hire and first patient contact 11/15/12, failed to evidence the employee had been oriented to the position of home health aide, a dated job description, a criminal history background check, and documentation the aide was listed on and in good standing on the home health aide state registry.</p> <p>6. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, failed to evidence the employee had been oriented to the position of home health aide and a criminal history background check under all names she revealed on her employment application.</p> <p>On 12/28/12 at 12:44 PM, employee I indicated the file did not contain a criminal history search under all names revealed on the employment application.</p> <p>7. Personnel record H, date of hire and first patient contact 11/15/12, evidenced the individual moved to the state of Indiana in 2012. The record failed to evidence a national criminal history check, orientation to the position of home health aide, a dated job description, and documentation the aide was listed on and in good standing on the home health aide state registry.</p>						

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	<p>8. On 12/31/12 at 5:30 PM, the administrator indicated the individuals providing aide services on behalf of the agency were not on the home health registry.</p> <p>9. The policy titled "General Orientation" dated 4/18/11, states, "Orientation is planned over a 2 week period and can be extended The orientation is individually planned depending on the employee's job classification, prior experience, and assignments.</p> <p>10. The policy titled "Employment Procedures" dated 6/15/11, stated, "Home Health Aides should be asked for a copy of their certification which will be confirmed with the state in compliance with regulations</p>			

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N0460	<p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:</p> <p>(1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on personnel record review and interview, the agency failed to ensure personnel files of the supervising nurse and alternate contained all required documentation for 2 of 2 supervising nurse files reviewed (A and D) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Personnel file A, date of hire 3/5/12, received from Olympia, Illinois, electronically, failed to evidence the individual was oriented to the position of the administrator, director of nursing, and registered nurse and a dated job description for the position of the administrator, director of nursing, and registered nurse.</p>	N0460	The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review the policies; "General Orientation" 6.1.0, dated 4/18/2011, "Orientation for Office Staff" 6.5.0, dated 4/19/2011, "Orientation for Nursing Staff" 6.6.0, dated 4/19/2011 and "Employment Procedures" 9.3.0, dated 6/15/2011, and reviewed Job Descriptions; "Administrator/Agency Director" 5.1.0, dated 6/16/2011, and "Director of Patient Care Services" 5.3.0, dated 5/4/2011. This will provide the Administrator/Agency Director information of functions within the agency, compliance with regulations, and Agency's function within the community. Orientation policies will instruct the Administrator/Agency Director on the Agency's philosophy,	02/05/2013			

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	<p>2. Personnel file D, date of hire 7/5/11, received from Olympia Field, Illinois, electronically, failed to evidence a dated job description, documentation of orientation to the position as the alternate director of nursing, and a national criminal history pursuant to IC 16-27-2. The file evidenced the individual was a resident of the state of Illinois.</p> <p>3. On 12/28/12 at 2:22 PM, the administrator indicated there was no further information available.</p>		<p>policies, and procedures related to his specific responsibilities.</p> <p>Administrator/Agency Director has reviewed the above and been reoriented as needed to his duties and responsibilities and signed job descriptions, has had a criminal history pursuant to IC 16-27-2 completed, licensure verified with State Agencies and items added that were not correctly filed.</p> <p>Administrator/Agency Director will provide the above policies and job descriptions to the Alternate Director of Patient Care Services and assist with orientation as well as completion or addition of any items needed for personnel file completion.</p> <p>Administrator/Agency Director shall audit all personnel records by 2/5/2013 to ensure compliance.</p> <p>Administrator/Agency Director shall audit all personnel records monthly thereafter until 100% percent are within compliance. Personnel records shall all be reviewed quarterly thereafter.</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 record and policy review and interview, the agency failed to ensure all employees had a physical examination no more than 180 days before direct patient contact for 7 of 7 files of direct care staff reviewed (A, C, D, E, F, G, and H) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel record A, a registered nurse, date of hire 3/19/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. 2. Personnel record C, a registered nurse, date of hire 7/5/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from 	N0462	<p>All staff were provided information on policy "Employment Health Requirements" 9.2.0, dated 6/13/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation. Staff has been instructed to provide proof of Health Assessment/Physical Exam dated no sooner than 180 days prior to their date of first patient contact. Each employee was provided a standardized form to be completed and signed by their physician, which states that they able to perform patient care and do not pose a direct threat to the health and safety of themselves or others, that they are physically well and free of communicable disease. They must provide TB screening per policy 9.2.0 and state regulation, having record of (2) Mantoux skin tests in the previous 1 year and be tested annually thereafter or chest x-ray if there is documented history of a positive Mantoux test and must sign an attestation on</p>	02/05/2013			

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	<p>communicable disease.</p> <p>3. Personnel file D, a registered nurse, date of hire 10/2/11, failed to evidence a physical examination of sufficient scope to determine the individual was free from communicable disease.</p> <p>4. Personnel record E, a home health aide, date of hire and first patient contact 9/26/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 10/26/12.</p> <p>5. Personnel record F, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease.</p> <p>6. Personnel record G, a home health aide, date of hire 8/3/12 and first patient contact 8/23/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 8/31/12.</p>		<p>the "Tuberculosis Screening Questionnaire" identifying that the applicant is free from signs and symptoms of tuberculosis. Employees must accept or decline Hepatitis B Vaccine. All staff providing direct patient contact must provide this current documentation and confidential personnel health records must contain copies. Personnel health records shall be created and contained separate and confidential from other personnel files and be secured from all staff besides Administrator/Agency Director and Director of Nursing. The Administrator/Agency Director will review 100%, of the current personnel records, by 2/5/2013, to ensure that all records are within compliance. Thereafter this will be done on a quarterly basis until 100% compliance is achieved, and then the audits will be performed annually.</p>				

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	<p>7. Personnel record H, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence the employee had a physical examination 180 days prior to patient contact that identified the employee was free from communicable disease. The file evidenced a physical examination dated 12/17/12.</p> <p>8. On 12/28/12 at 2:22 PM, the administrator / director of nursing indicated there was not any further information available.</p> <p>9. The policy titled "Employment Health Requirements - Employee Providing Patient Care" states, "The agency requires that all employees with direct patient contact adhere to state requirements of employee health to ensure that the employee is physically and medically able to perform their assigned duties and that the employee has no health condition that would create a hazard to patients or themselves."</p>				

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N0464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>						

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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel record and policy review, the agency failed to ensure all direct care staff files included screening for tuberculosis with a two step PPD at employment or 2 negative PPDs within the previous 12 months for 1 of 1 supervising nurse (A) and 3 of 4 home health aide files reviewed (E, F, and H) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel record A, date of hire 3/19/12, failed to evidence a negative tuberculosis screening within the previous 12 months or a two step PPD had been administered. Personnel record E, a home health aide, date of hire and first patient contact 9/26/12, failed to evidence two or more negative tuberculosis screening within the previous 12 months. The file 	N0464	<p>All staff were provided information on policy "Employment Health Requirements" 9.2.0, dated 6/13/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation. Staff has been instructed to provide proof of Health Assessment/Physical Exam dated no sooner than 180 days prior to their date of first patient contact. Each employee was provided a standardized form to be completed and signed by their physician, which states that they able to perform patient care and do not pose a direct threat to the health and safety of themselves or others, that they are physically well and free of communicable disease. They must provide TB screening per policy 9.2.0 and state regulation, having record of (2) Mantoux skin tests in the previous 1 year and be tested annually thereafter or chest x-ray if there is documented history of a positive Mantoux test and must sign an attestation on the "Tuberculosis Screening</p>	02/05/2013	

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	<p>evidenced a Mantoux dated 10/26/11.</p> <p>3. Personnel record F, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence a negative tuberculosis screening within the previous 12 months or that a two step PPD had been administered.</p> <p>4. Personnel record H, a home health aide, date of hire and first patient contact 11/15/12, failed to evidence a negative tuberculosis screening within the previous 12 months or that a two step PPD had been administered.</p> <p>5. The policy titled "Employment Health Requirements - Employee Providing Patient Care" states, "The agency requires that all employees with direct patient contact adhere to state requirements of employee health to ensure that the employee is physically and medically able to perform their assigned duties and that the employee has no health condition that would create a hazard to patients or themselves. All applicants whose ... offer of employment of employment requires or may require them to provide patient care must submit the following evidence that they do not have infectious tuberculosis ... Tuberculosis - Mantoux Skin Testing ... The Mantoux</p>		<p>Questionnaire" identifying that the applicant is free from signs and symptoms of tuberculosis. Employees must accept or decline Hepatitis B Vaccine. All staff providing direct patient contact must provide this current documentation and confidential personnel health records must contain copies. Personnel health records shall be created and contained separate and confidential from other personnel files and be secured from all staff besides Administrator/Agency Director and Director of Nursing. The Administrator/Agency Director will review 100%, of the current personnel records, by 2/5/2013, to ensure that all records are within compliance. Thereafter this will be done on a quarterly basis until 100% compliance is achieved, and then the audits will be performed annually. See exhibit #G141</p>				

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	<p>skin test can be waived if the applicant can provide results of two or more negative Mantoux skin tests results within one year before employment with the most recent Mantoux skin test read within ninety (90) days before the date of offer of employment."</p> <p>6. On 12/28/12 at 2:22 PM, the administrator / director of nursing indicated there was not any further information available.</p>			

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N0466	<p>410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on observation, interview, and review of policies, the agency failed to ensure the confidential medical records were separate from personnel information for 5 of 7 direct care staff records reviewed (files C, E, F, G, and H).</p> <p>The findings include:</p> <p>1. On 12/28/12 at 11:32 AM, the tuberculosis monitoring and physical examination information for personnel files E, F, G, and H were observed housed in the same personnel file as the personnel information in the second drawer of a file cabinet in the office of the administrator. The health information file for employee C was in a separate folder and kept with the personnel information within the same drawer. The administrator indicated he was not aware the information needed to be kept separate and confidential.</p> <p>2. The policy titled "Employment</p>	N0466	All staff were provided information on policy "Employment Health Requirements" 9.2.0, dated 6/13/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation. Staff has been instructed to provide proof of Health Assessment/Physical Exam dated no sooner than 180 days prior to their date of first patient contact. Each employee was provided a standardized form to be completed and signed by their physician, which states that they able to perform patient care and do not pose a direct threat to the health and safety of themselves or others, that they are physically well and free of communicable disease. They must provide TB screening per policy 9.2.0 and state regulation, having record of (2) Mantoux skin tests in the previous 1 year and be tested annually thereafter or chest x-ray if there is documented history of a positive Mantoux test and must sign an attestation on the "Tuberculosis Screening	02/05/2013			

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	Procedures" dated 6/15/11 stated, "All personnel and medical information is maintained separately in confidential files."		Questionnaire" identifying that the applicant is free from signs and symptoms of tuberculosis. Employees must accept or decline Hepatitis B Vaccine. All staff providing direct patient contact must provide this current documentation and confidential personnel health records must contain copies. Personnel health records shall be created and contained separate and confidential from other personnel files and be secured from all staff besides Administrator/Agency Director and Director of Nursing. The Administrator/Agency Director will review 100%, of the current personnel records, by 2/5/2013, to ensure that all records are within compliance. Thereafter this will be done on a quarterly basis until 100% compliance is achieved, and then the audits will be performed annually.		

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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 on document review, policy review, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program (QAPI) was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. Administrative documents failed to evidence the agency conducted an ongoing quality improvement program. The information submitted was reviewed. The most recent information was dated May 2010 and titled "Quarterly</p>	N0472	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review the policy "Performance Improvement Plan" 3.4.0, dated 1/31/2011, and develop a plan to include: Monitoring policies, procedures, and practices to ensure that they provide for a high quality of care and effective operations, Monitor adverse event reports, Utilize OBQI and OBQM, as available, reports to identify performance improvement opportunities, Monitor Patient and physician/referral source satisfaction with services to ensure needs are met, Monitor unusual occurrences and grievances to prevent reoccurrence, Maintain compliance with applicable federal and state regulations, Ensure the accuracy and appropriateness of the plan of</p>	02/05/2013			

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	<p>Multidisciplinary Clinical Record Review." The agency failed to evidence any planning to assess the quality of and to improve patient care.</p> <p>2. On 12/28/2012 at 4 PM, the surveyor requested a copy of the quality insurance performance improvement program (QAPI). The administrator indicated there was no recent documentation and stated, "We are small."</p> <p>3. The policy titled Performance Improvement Plan" dated 11/02/09 and stated, "The Performance Improvement Plan will be reviewed / revised annually. Specific objectives of the plan include: Monitor policies, procedures and practices ... Monitor adverse events reports and address and resolve identified or potential problems ... Monitor patient and physician / referral source satisfaction ... Monitor infection control log and address identified or potential problems."</p>		<p>care in meeting individualized patient needs, Monitor infection control log, Monitor patient complaints and resolutions, evaluate patient outcomes, ensure accurate and timely completion and transmission of OASIS assessments, and Ensure timely and accurate billing of services. High risk processes will be monitored to include infectious diseases, wounds, and patient falls. Monitoring and evaluation of the processes will be designed to facilitate systematic, organized problem solving and improvement. Reports of the evaluations will be distributed to the Professional Advisory Committee, corporate management and the governing body for review on an annual or more frequent basis, if indicated. Identification of problems or opportunities for improvement, actions to facilitate improvement will be developed and prioritized by severity. Once areas of improvement have been selected the Administrator/Agency Director; with input from the PAC, management, agency staff and the governing body will develop a systematic plan of implementation of the improvement activity. All agency policies for confidentiality will be followed when conducting QAPI activities. No results which contain patient's identifiable information will be released.</p>				

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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 and interview, the agency failed to ensure the personnel furnishing services implemented effective communication to promote the objectives identified in the plan of care for 1 of 13 records reviewed with the potential to affect all the patients of the agency (Clinical record #8).</p> <p>Findings include:</p>	N0484	<p>The Field Clinicians were In-serviced on the policy "Patient Plan of Care", 4.4.0 dated 6/7/11 on 1/3/2013 and specific attention was given to section 5, under the subheading "policy" which states "the plan of care should be developed, implemented and revised in coordination with the patient, the physician and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice. Field clinicians will adhere to the requirement, under subheading "procedure" #4, which states that "the plan of care and revisions should be communicated effectively to the patient, physician and any other members of the health care team." Failure to do so will result in disciplinary action.</p> <p>The Performance Improvement Coordinator will review 25% of the medical records to ensure that all problems, precautions or contraindications have been effectively communicated to the interdisciplinary team, have been</p>	01/03/2013	

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	<p>1. Clinical record #8, start of care 12/4/12, evidenced the patient was receiving dialysis on Tuesday and Thursday and the aide was providing a bath for the patient. The record failed evidence the nurse had communicated to the aide, who was bathing the patient, about the fistula, risks and precautions during care.</p> <p>2. On 12/31/12 at 2:20 PM, Employee A, the director of nursing, indicated the patient had a right arm fistula for dialysis and that coordination of care had not occurred between the aide and skilled nurse.</p>		<p>included in the Plan of Care (HCFA-485) and included on the Home Health Aide/Homemaker Care Plan, under the section "Special Instructions/Safety Precautions", if applicable. A copy of these documents will be placed in the patient record, in the patient's home and provided to each applicable team member. Field Clinicians will personally provide these documents to the Home Health Aide and verbally report all "Special Instructions/Safety Precautions". This will be done on a monthly basis until 100% compliance is achieved, and then the audits will be performed quarterly.</p>		

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N0486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review and interview, the agency failed to ensure coordination of care occurred with other entities providing services for 2 of 2 (# 1 and 9) records reviewed of patients receiving services from other entities with the potential to affect all patients receiving services from another entity.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record # 1, start of care 9/18/12, failed to evidence coordination of care with the other providers of care. <p>On 12/31/12 at 8:30 AM during a home visit, the patient's neighbor was observed to administer the patient's medications and employee G indicated the patient had another agency in the home through 12/30/12 for aide services for 12 hours a day, 7 days a week.</p> <ol style="list-style-type: none"> Clinical record 9, start of care 8/24/12, included a comprehensive assessment that documented the patient diagnoses of paraplegia, chairfast, and a stage four pressure ulcer at the sacral / coccyx area. The record did not evidence coordination 	N0486	<p>All Field Clinicians and Administrative staff were in-serviced on policy "Coordination of Services" 4.5.0, dated 4/18/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation which will be documented in their orientation check list.</p> <p>The primary nurse is responsible for the coordination of services to assigned patients and for the ongoing evaluation of the patient's needs. This will begin with the admission process and be documented on the plan of care, be ongoing, both formal and spontaneous and will be documented in a timely basis. Coordination of care will be documented in the clinical record on the "visit note" or on a case conference/case management note. Updates will be included on the "60 day summary note" and be provided to the physician as required every 60 days.</p> <p>The Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance and then the audits will be performed quarterly.</p>	01/03/2013			

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	<p>of care with any caregivers.</p> <p>On 12/31/12 at 1 PM, employee A indicated the patient received homemaking services through a personal care service agency.</p>				

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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 admission rights document review and interview, the agency failed to ensure it had developed a discharge policy that included a 5-day notice of discharge for 1 of 1 agency creating the potential to affect all of the agency's current patients.</p> <p>The findings include:</p>	N0488	The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed discharge packets submitted by the field clinicians for the inclusion of the comprehensive discharge assessment, and delegate the responsibility to the Clinical	02/05/2013			

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	<p>1. The agency admission information delivered to all patient's at admission titled "Statement of Patient Rights and Responsibilities" stated, "Please be advised that any patient ... consistently refuses a service, or is non-compliant with his / her ordered treatment may be discharged after being given a minimum of three (3) days notice."</p> <p>2. Employee A indicated the Addus corporation policy was a 3 day notice of discharge and the agency did not develop and implement a 5 day notice of discharge, when asked on 12/27/12 at 2:05 PM.</p>		<p>Support Coordinator to fax the discharge summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3 rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011, "Discharge and Transfer of Patients" 2.13.0, dated 4/13/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time. Field Clinicians will be responsible for providing 5 day notice of discharge, obtain orders to discharge patient and completing the comprehensive discharge assessment and gathering OASIS discharge information. The policy "OASIS " 2.14.0, dated 4/14/2011 and policy "Discharge and Transfer of Patients" 2.13.0, dated 4/13/2011 were in-serviced by the Administrator/Agency Director to all Field Clinicians and Clinical Support Coordinators on January 3 rd , 2013. The Administrator/ Agency Director will provide to the clinical support coordinator instruction on how to correct the Patient Information Booklet. The</p>		

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			Administrator/Agency Director will delegate to the Clinical Support Coordinator the task of correcting the Patient Information Booklets. The section on page three entitled "Statement of Patients Rights, The Responsibility To:" will be changed as exhibit #N488 shows to provide for 5 day notice of discharge. These corrected Patient Information Booklets have been included with the in-servicing on 1/3/2013 and presented in conjunction with policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011. Administrator/ Agency Director will review, by 2/5/2013, other agency collateral and printed materials to ensure that any instances of "patient rights" will be corrected. See exhibit #N488	

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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 review and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 6 of 13 clinical records reviewed with the potential to affect all the patients of the agency. (# 2, 3, 6, 7, 8, and 12)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record 2, start of care 11/15/12, failed to evidence the patient nor their guardian had been notified of the patient rights. On December 28, 2012, at 4:30 PM, the administrator indicated there was no further information. 	N0494	<p>The Patient's Notice of Rights are included in the Patient Handbook that is in the Start of Care packets. Effective 1/3/2013, the registered nurse conducting the initial assessment reviews/advises the patient or patient's representative of their rights both verbally and in writing prior to formal admission. A checklist has been developed and is included in the Start of Care packets. Upon completion of advising the patient or patient's representative of their rights the RN will document this on the checklist. The checklist will be submitted with the completed start of care paperwork and is filed in the patient's record. All Field Clinicians and Administrative staff were in-serviced on policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011, on</p>	01/03/2013			

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	3. Clinical records #3, #6, #7, #8, and #12 failed to evidence the agency had informed the patient or the patient's legal representatives of their rights.		1/3/2013 by the Administrator. New staff will receive training as part of their orientation. The Performance Improvement Coordinator and/or designee will review 100% of the new admission records on a monthly basis to ensure compliance. When 100% compliance has been achieved the audits will be performed on a quarterly basis. 100% of all new admission records will continue to be reviewed. The Administrator is responsible for monitoring the Performance Improvement Coordinator and ensuring that reviews are completed. See exhibit #G101	

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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 interview and review of policy, it was determined the agency failed to ensure confidentiality of patient identifiable information and OASIS data items for 1 of 1 agency reviewed with the potential to affect all current and past patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/27/12 at 1:10 PM, employee A indicated an individual who was not an employee of the agency transmitted all the OASIS assessment items for all agency patients and provided the transmission validation reports to the agency via electronic mail. On 12/27/12 at 3 PM, employee A indicated there was not a written contract between the individual responsible for the transmission of the OASIS data items and 	N0508	<p>Administrator/Agency Director is responsible for maintaining the standard. Per Addus policy, "Oasis – Outcome and Assessment Information Set" 2.14.0, dated 4/14/2011, paragraph 14, under sub heading "procedure", " Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data." An employee of Addus Healthcare, Inc. was responsible for the transmission of locked OASIS assessments, but the employee was not located at the Agency. Administrator/Agency Director provided a copy of the employee's signed job description, outlining her role in OASIS data transmission, her signed HIPAA statement and her non-disclosure agreement. Per 42 CFR 484.11, it was determined that the employee was not a direct employee of the</p>	01/07/2013			

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	<p>provision of validation reports to the agency. He indicated the patients were not informed that their information was going to be shared with this individual outside of the agency.</p> <p>3. The policy titled "OASIS - OUTCOME AND ASSESSMENT INFORMATION SET / COMPREHENSIVE ASSESSMENTS" stated, "Any contractors that would have access to OASIS data will be required to have a confidentiality clause in their written contract to protect the confidentiality of OASIS data."</p>		<p>agency and thus required a written contract. On January 7 th , 2013, A HIPAA Business Associate Agreement was mutually executed to address 42 CFR 484.11. According to Article IV "Term and Termination", number 1 "Term", the agreement shall be effective the first day of the Business Associates employment and shall run through the duration of the time the business associate is responsible for the entry and transmission of OASIS data for Addus Healthcare (Indiana), Inc. Administrator/Agency Director shall ensure that any future individual(s), who is given access to OASIS data for transmission purposes, shall enter into and be bound by a similar contract prior to any access being given. See Exhibit #G111</p>		

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N0512	<p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse. (B) Treated with dignity. Based on interview and review of admission documents, the agency failed to ensure the patient was advised of the right to be free of verbal, physical, and psychological abuse in 13 of 13 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13) with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Admission documents given to the patient and/or family at the start of care included a form titled "Statement of Patient Rights and Responsibilities." The form failed to include the right to be free of verbal, physical, and psychological abuse. Clinical records #2, 3, 6, 7, 8, and 12 failed to evidence the patient had received the patients rights document. Clinical records #1, 4, 5, 9, 10, 11, and 13 evidenced the patient and/or family 	N0512	<p>The Administrator/ Agency Director will provide to the clinical support coordinator instruction on how to correct the Patient Information Booklet. The Administrator/Agency Director will delegate to the Clinical Support Coordinator the task of correcting the Patient Information Booklets. The section on page three entitled "Statement of Patients Rights" will be removed and in its place exhibit #N512 "Patient Bill of Rights" will be added to the Patient Information Booklet. This will address the issue and include Administrator/Agency Director will inform Addus HomeCare Corporation printing department of the changes so that they are reflected in future print runs. 4. The patient has the right to be as follows: (a.) Free from verbal, physical, and psychological abuse. (b.) Treated with dignity. These corrected Patient Information Booklets have been included with the in-servicing on 1/3/2013 and presented in conjunction with policy "Evaluation/Admission Process"</p>	02/05/2013			

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	<p>had received the same admission documents titled "Statement of Patient Rights and Responsibilities" upon admission.</p> <p>4. At 2:05 PM on December 27, 2012, the administrator indicated the patient right form and the admission booklet information that was given to the patients and/or family at the start of care failed to include the right to be free of verbal, physical, and psychological abuse.</p>		<p>4.1.0, dated 4/14/2011. Administrator/ Agency Director will review, by 2/5/2013, other agency collateral and printed materials to ensure that any instances of "patient rights" will be corrected. See exhibit #N512</p>		

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N0516	<p>410 IAC 17-12-3(d) Patient Rights Rule 12 Sec. 3(d) (d) The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency as defined in 42 CFR § 420.201, 42 CFR § 420.202, and 42 CFR § 420.206, in effect on July 1, 2005.</p> <p>Based on patient rights document and clinical record review and interview, the agency failed to ensure the patient was informed of the right to request, and be provided, a listing of all individuals or legal entities who have an ownership or controlling interest in the agency for 13 of 13 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13) with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The agency admission document titled "Addus Healthcare Home Health Care Division Patient Information Booklet" contained the "Statement of Patient Rights and Responsibilities." The admission information failed to inform the patient of the right to request, and be provided, a listing of all individuals or legal entities who have an ownership or controlling interest in the agency.</p>	N0516	<p>The Administrator/ Agency Director will provide to the clinical support coordinator instruction on how to correct the Patient Information Booklet. The Administrator/Agency Director will delegate to the Clinical Support Coordinator the task of correcting the Patient Information Booklets. The section on page three entitled "Statement of Patients Rights" will be removed and in its place exhibit #N488 "Patient Bill of Rights" will be added to the Patient Information Booklet. This will address the issue and include</p> <p>6. The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency.</p>	02/05/2013			

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	<p>2. Clinical records #2, 3, 6, 7, 8, and 12 failed to evidence the patient had received the patients rights document.</p> <p>3. Clinical records #1, 4, 5, 9, 10, 11, and 13 evidenced the patient and/or family had received the same admission documents titled "Statement of Patient Rights and Responsibilities" upon admission.</p> <p>4. At 2:05 PM on December 27, 2012, the administrator indicated the patient right form and the admission booklet information that was given to the patients and/or family at the start of care failed to include the right to be free of verbal, physical, and psychological abuse.</p>		<p>Administrator/Agency Director will inform Addus HomeCare Corporation printing department of the changes so that they are reflected in future print runs.</p> <p>These corrected Patient Information Booklets have been included with the in-servicing on 1/3/2013 and presented in conjunction with policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011.</p> <p>Administrator/ Agency Director will review, by 2/5/2013, other agency collateral and printed materials to ensure that any instances of "patient rights" will be corrected.</p> <p>See exhibit #N512</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 policy review and interview, the agency failed to ensure the visits and treatments were made as ordered on the plan of care and care was provided only as ordered on the plan of care in 9 of 13 records reviewed (# 1, 3, 4, 5, 6, 8, 10, 11, and 12) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 9/18/12, included documentation employee E provided aide services on November 18, 23, and 24; employee G provided aide services on November 16, 19, 20, 21, 26, 27. 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012; employee I provided aide services on December 1, 2, 8, 9, and 15, 2012; and employee J provided services on November 19, 2012. The clinical record failed to evidence a plan of care or verbal orders for the services provided by the agency.</p> <p>On 12/27/12 at 2:55 PM, employee A</p>	N0522	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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. Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will obtain all orders necessary to provide any care that will be provided by agency personnel. Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments,</p>	02/05/2013			

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	<p>indicated the clinical record did not contain a plan of care for the services provided after November 16, 2012.</p> <p>2. Clinical record 4, start of care 11/14/12, evidenced a physician order dated 11/18/12 for one skilled nurse visit every other week for 5 weeks and to obtain a complete blood count, comprehensive metabolic panel, and a prothrombin time every 2 weeks until otherwise ordered.</p> <p>A. The clinical record evidenced 2 skilled nurse visits only, one dated 11/14/12, the date of the start of care, and the second visit was dated 11/29/12. The record failed to evidence why no further visits were provided.</p> <p>B. On 12/28/12 at 4:38 PM, employee A indicated the patient was discharged on 12/28/12 due to employee C being unable to locate the patient and the documentation should be in the clinical record.</p> <p>3. Clinical record 5, start of care 11/16/12, included a plan of care for the certification period 11/16/12 through 1/14/12 with orders for skilled nursing once a month and aide visits 3 times a week. The record evidenced only 2 visits were provided during week 4 on 12/5 and</p>		<p>interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action.</p> <p>Clinical Support Coordinators were also in-serviced by the Administrator/Agency Director on policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders.</p> <p>Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support</p>				

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	<p>12/7/12 and 2 visits were provided during week 5 on 12/10/12 and 12/12/12. The clinical record failed to evidence why the visits were not made.</p> <p>4. Clinical record # 10, start of care 8/21/12, evidenced a plan of care dated 10/20/12 with orders for aide services 2 times a week for eight weeks. The record evidenced aide services were provided on October 23, 26 and 29 and November 16, 19, 23, and 26, 2012. The record failed to evidence any services were provided between October 29, 2012 and November 16, 2012. The record failed to evidence why the visits were not made.</p> <p>5. Clinical record 11, start of care 9/4/12, included a plan of care for the certification period 9/4/12 through 11/2/12 for aide services two times a week for one week and three times a week for eight weeks and skilled nurse visits one time a month for 3 months. The record failed to evidence any aide services were provided during week one; only two visits were provided during week four, on 9/26/12 and 9/28/12; and two visits were provided during week six on 10/8/12 and 10/10/12. The record failed to evidence why aide services were not provided as ordered.</p> <p>On 12/31/12 at 4:24 PM, employee A</p>		<p>Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director.</p> <p>Effective 1/22/2013, Clinical Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken.</p> <p>An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly.</p> <p>See exhibit #G159</p>				

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	<p>indicated there was no documentation to explain why the visits were not made.</p> <p>6. The policy titled "Physician's Plan of Care / Treatment and Notification of Patient's Change in Condition" dated 4/18/11 and stated, "Home health services should be provided in accordance with an individualized plan of care. ... Modifications / additions to the plan of care / plan of treatment must be approved by the attending physician. Physician will be notified of unforeseen missed visits. ... The plan of care / plan of treatment should include; ... Specific treatments and modalities for each discipline including amount frequency and duration."</p> <p>7. Clinical record #3, start of care (SOC) 7/20/12, included a plan of care (POC) for the certification period of 11/17/12 - 1/15/12 with orders that stated, "Nursing to maintain and change suprapubic catheter every three weeks and prn [as needed] q [every] week with 16 fr [french] 5 cc [cubic centimeter] catheter."</p> <p>a. The clinical record document titled "Nurse Visit Note" signed by Employee C, RN, on 11/26/12, stated, under Skilled Interventions, "Catheter change 22 French 10 cc [cubic centimeter] ... intact and draining."</p>			

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	<p>b. The "Nurse Visit Note" signed by Employee C on 12/24/12 stated, under Skilled Interventions, "Catheter change ... instilled 22 French 10 cc [cubic centimeter] balloon inflated with 10 cc intact draining flushed with 120 cc normal saline." The POC failed to evidence an order for the catheter to be flushed.</p> <p>c. On 12/28/12 at 4:45 PM, Employee A, the director of nursing, indicated the RN did not follow the POC.</p> <p>8. Clinical record #6, SOC 12/6/12, failed to evidence a POC. A skilled nurse visit occurred on 12/6/12. Aide visits occurred on 12/11/12 and 12/13/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was no written POC in this record.</p> <p>9. Clinical record #8, SOC 12/4/12, failed to evidence a POC. The records evidenced a skilled nurse visit occurred on 12/4/12 and Aide visits occurred on 12/6/12, 12/11/12, 12/13/12, and 12/14/12.</p> <p>On 12/31/12 at 2 PM, Employee A indicated the written POC was not in the record.</p>						

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	<p>10. Clinical record #12, SOC 10/8/12, included a plan of care for the certification period of 10/8/12 - 12/6/12 that stated, "Aide 5 [times a] week [for] 9 [weeks]... SN [skilled nurse] 3 [times a] week 9 ... SN to supervise HHA [home health aide] 2 x month."</p> <p>a. The clinical record evidenced nurse visits on 10/10/12, 10/11/12, 10/22/12, 10/24/12, 10/29/12, 11/2/12, and 11/5/12 and "physician notice of visit frequency" (physician notice of missed skilled nurse visits) on 10/12/12, 10/20/12, 10/31/12, 11/7/12, 11/10/12. There were no more skilled nurse visits or missed skilled nurse visit notices noted after 11/10/12 until 12/6/12. There was no supervisory note from a skilled nurse in this time frame either.</p> <p>b. The clinical record evidenced aide visits on 10/8/12, 10/9/12, 10/10/12, 10/11/12, 10/12/12, 10/15/12, 10/16/12, 10/17/12, 10/19/12, 10/22/12, 10/23/12, 10/24/12, 10/25/12, 10/26/12, 11/6/12, 11/8/12, 11/9/12, 11/14/12, 11/15/12, 11/16/12, 11/21/12, 11/23/12, 11/28/12, 11/29/12, 11/30/12, 12/4/12, 12/5/12, and 12/6/12. No visits occurred the week of 10/28/12 - 11/3/12. Visits were reduced to two or three times a week after 11/4/12 for the rest of the certification period with</p>						

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	no update to the plan of care. c. On 12/31/12 at 4:40 PM, Employee A indicated care did not follow the written plan of care.				

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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 and policy review and interview, the agency failed to ensure the plans of care included all the required elements for 5 of 13 (records 1, 2, 6, 8, and 11) clinical record reviewed, creating the potential for omission of care and to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 9/18/12, included documentation</p>	N0524	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being</p>	02/05/2013			

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	<p>employee E provided aide services on November 18, 23, and 24; employee G provided aide services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012; employee I provided aide services on December 1, 2, 8, 9, and 15, 2012; and employee J provided services on November 19, 2012. The clinical record failed to evidence a plan of care or verbal orders for the services provided by the agency.</p> <p>On 12/27/12 at 2:55 PM, employee A indicated the clinical record did not contain a plan of care for the services provided after November 16, 2012.</p> <p>2. Clinical record # 2, start of care 11/15/12, evidenced documentation that employee F provided aide services on November 19 and 20, 2012 which lasted for 4 hours each; aide services on November 21, 22, 23, 26, and 27, 2012 which lasted for 5.5 hours; on November 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012 the aide visits lasted 6 hours each. The plan of care for the certification period 11/15/12 through 1/13/12 failed to evidence an order for the frequency of the visits to be provided.</p> <p>On 12/28/12 at 4:25 PM, employee A indicated the record did not contain an</p>		<p>provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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>Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will obtain all orders necessary to provide any care that will be provided by agency personnel. Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments, interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/- or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action.</p> <p>Clinical Support Coordinators were also in-serviced by the Administrator/Agency</p>				

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	<p>order for the frequency of the aide visits.</p> <p>3. Clinical record 11, start of care 9/4/12, evidenced a skilled nurse note and comprehensive assessment dated 12/10/12 by employee C and aide services were provided by employee I on 12/11/12. The record failed to evidence an order for the visits on 12/10/12 and 12/11/12.</p> <p>On 12/31/12 at 4 PM, employee A indicated the agency was not able to obtain physician signature for the orders received and was informed by the veteran's administration that the patient should not have been discharged on 11/2/12.</p>		<p>Director on policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders.</p> <p>Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director.</p> <p>Effective 1/22/2013, Clinical Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure</p>		

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	<p>4. Clinical record #6, SOC 12/6/12, failed to evidence a plan of care (POC). A skilled nurse visit occurred on 12/6/12. Aide visits occurred on 12/11/12 and 12/13/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was not a POC in the record.</p> <p>5. Clinical record #8, SOC 12/4/12, failed to evidence POC. A skilled nurse visit occurred on 12/4/12. Aide visits occurred on 12/6/12, 12/11/12, 12/13/12, and 12/14/12.</p> <p>On 12/31/12 at 2 PM, Employee A indicated the POC was not in the record.</p>		<p>continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken.</p> <p>An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly.</p> <p>See exhibit #G159</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:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure a written summary was sent to the physician every 60 days in 5 of 5 records reviewed of patients receiving care longer than 60 days with the potential to affect all the agency's patients receiving services longer than 60 days. (1, 3, 9, 10, and 12)</p> <p>The findings include;</p> <p>1. Clinical record 1, start of care 9/18/12, failed to evidence a 60 day summary was sent to the attending physician.</p> <p>On 12/31/12 at 1:40 PM, employee A indicated the 60 day summaries were to be written on the OASIS recertification document and that the OASIS data was sent to the physician.</p> <p>2. Clinical record 9, start of care 8/24/12, failed to evidence a 60 day summary was sent to the attending physician.</p> <p>3. Clinical record 10, start of care</p>	N0529	<p>The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed recertification packets submitted by the field clinicians for the inclusion of the 60 day summary, and delegate the responsibility to the Clinical Support Coordinator to fax the 60 day summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3 rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time.</p> <p>The Performance Improvement</p>	01/03/2013			

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	<p>8/21/12, failed to evidence a 60 day summary was sent to the attending physician.</p> <p>4. The undated policy titled "Clinical Record Content and Maintenance" and states, "The client's clinical record will contain ... Copies of Sixty (60) day Summary."</p> <p>5. The policy titled "Coordination of Services" dated 4/18/11 stated, "A summary of services report of pertinent facts from the clinical and progress notes is sent to the patient's attending physician every 60 sixty (60) to sixty - two (62) days."</p> <p>6. The policy dated 5/4/11 titled "Clinical records" stated, "The home health clinical records contain the following: ... Written summary reports are sent to the patient's physician every 60 days - these may be sent every 62 days on non-OASIS patients where allowed by state regulation."</p> <p>7. On 12/31/12 at 1:40 PM, employee A indicated the 60 day summaries were to be written within the electronic OASIS recertification information and that the recertification, including the OASIS data, was to be printed and sent to the physician.</p>		<p>Coordinator or Designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved. Then the audits will be performed quarterly.</p> <p>See exhibit #G145</p>				

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	<p>8. Clinical record #3, start of care (SOC) 7/20/12, failed to evidence the 60 day summary had been completed for the certification periods of 11/17/12 - 1/15/12 and 9/18/12 - 11/16/12.</p> <p>9. Clinical record #12, SOC 10/8/12, failed to evidence the 60 day summary had been completed for the certification periods of 10/8/12 - 12/6/12 and 12/7/12 - 2/5/12.</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:</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse provided services as ordered in accordance with the plan of care for 4 of 13 records reviewed with the potential to affect all the agency's current patients. (# 3, 6, 8, and 12)</p> <p>The findings include:</p> <p>1. Clinical record #3, start of care (SOC) 7/20/12, included a plan of care (POC) for the certification period of 11/17/12 - 1/15/12 with orders that stated, "Nursing to maintain and change suprapubic catheter every three weeks and prn [as needed] q [every] week with 16 fr [french] 5 cc [cubic centimeter] catheter."</p> <p>a. The clinical record document titled "Nurse Visit Note" signed by Employee C, RN, on 11/26/12, stated, under Skilled Interventions, "Catheter change 22 French 10 cc [cubic centimeter] ... intact and draining."</p> <p>b. The "Nurse Visit Note" signed by</p>	N0537	<p>On January 3 rd , 2013 the Administrator/Agency Director In-serviced the Clinical Support Coordinators and Field Clinicians on the policies; "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care", 4.4.0 dated 6/7/11 and the requirement that physician must be contacted and orders obtained for the initial Plan of Care and any new/changed orders that are not ordered on the Plan of Care. The Plan of Care will: Be developed in consultation with the home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, mental status, types of services and equipment required, frequency and duration 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.Effective 1/22/2013 the RN who completes the Initial Assessment and Start of Care will</p>	02/05/2013			

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	<p>Employee C on 12/24/12 stated, under Skilled Interventions, "Catheter change ... instilled 22 French 10 cc [cubic centimeter] balloon inflated with 10 cc intact draining flushed with 120 cc normal saline." The POC failed to evidence an order for the catheter to be flushed.</p> <p>c. On 12/28/12 at 4:45 PM, Employee A, the director of nursing, indicated the RN did not follow the POC.</p> <p>2. Clinical record #6, SOC 12/6/12, failed to evidence a POC. A skilled nurse visit occurred on 12/6/12.</p> <p>On 12/31/12 at 2:10 PM, the director of nursing indicated there was no written POC in this record.</p> <p>3. Clinical record #8, SOC 12/4/12, failed to evidence a POC. The records evidenced a skilled nurse visit occurred on 12/4/12.</p> <p>On 12/31/12 at 2 PM, Employee A indicated the POC was not in the record.</p> <p>4. Clinical record #12, SOC 10/8/12, included a plan of care for the certification period of 10/8/12 - 12/6/12 that stated, "Aide 5 [times a] week [for] 9 [weeks]... SN [skilled nurse] 3 [times a]</p>		<p>obtain all orders necessary to provide any care that will be provided by agency personnel. Orders will contain information to include: all services to be provided if a skilled service or home health aide only service is being provided, types of services and equipment required, frequency and duration of visits, medications and treatments, interventions, goals and staff required to provide care. Initially this will used to create the Plan of Care and will then be used to modify the existing Plan of Care during the interim of episodes. The Field Clinicians will submit to the Administrator/ Agency Director or designee all completed Start of Care and Recertification packets for review within 48 hours to ensure the Plan of Care/goal/intervention worksheets indicate all of the ordered disciplines. Once the 485 (Plan of Care) is completed the Administrator/ Agency Director +/- or designee will review to confirm orders for all disciplines, including frequency, duration, interventions and goals are present. This will ensure that all initial orders and frequencies have been obtained correctly and are being followed as prescribed by the Patient's Plan of Care. Failure to do so may result in disciplinary action. Clinical Support Coordinators were also in-serviced by the Administrator/Agency Director on</p>				

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	<p>week 9 ... SN to supervise HHA [home health aide] 2 x month."</p> <p>a. The clinical record evidenced nurse visits on 10/10/12, 10/11/12, 10/22/12, 10/24/12, 10/29/12, 11/2/12, and 11/5/12 and "physician notice of visit frequency" (physician notice of missed skilled nurse visits) on 10/12/12, 10/20/12, 10/31/12, 11/7/12, 11/10/12. There were no more skilled nurse visits or missed skilled nurse visit notices noted after 11/10/12 until 12/6/12. There was no supervisory note from a skilled nurse in this time frame either.</p> <p>b. On 12/31/12 at 4:40 PM, Employee A indicated care did not follow the written plan of care.</p>		<p>policy "Clinical Records" 2.16.0, dated 6/1/2011 and received proper training on filing documents, verifying dates, and matching with episode dates, the most recent documents on top. Exhibit #G159 signed by the Clinical Support Coordinators outlines the process for entering and tracking all physician orders. Effective 1/22/2013 the Clinical Support Coordinator will utilize Horizon scheduling system by entering frequency and duration into the system for each discipline. A SOC frequency will be entered for each discipline ordered. Clinician will submit his/her schedule weekly. Clinical Support Coordinator will compare schedule to visits scheduled in Horizon to ensure frequency and duration are met: If there is a discrepancy, Clinical Support Coordinator will notify nurse or Administrator /Agency Director. If a scheduled visit is missed or cancelled, the visit will be cancelled in Horizon and a note attached to the visit indicating why the visit was missed. A missed visit note will be printed and the physician will be notified. On a weekly basis the Incomplete Service Order Report will be generated to track visit notes and evaluations that have not been submitted to the office. The Clinical Support Coordinator will call the clinician and report to the Administrator/Agency Director. Effective 1/22/2013, Clinical</p>		

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			Supervisor shall review all notes (Nursing and Home Health Aide) provided by field clinicians to ensure that all orders are being followed during visits as prescribed by the Patient's Plan of Care and/or any interim orders which have changed/modified the Plan of Care. These notes will be compared to the staff initial weekly schedule and the Horizon Service Order Report to ensure continued compliance with the prescribed frequencies. Clinical Supervisor will inform Administrator/Agency Director of any discrepancies and corrective action will be taken. An initial audit, by 2/5/2013, of all active patient charts and discharged patient charts, within the past three months, will be completed to determine if missed visit notes can be added where applicable. Following this audit the Performance Improvement Coordinator +/- or designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis, starting March 2013, until 100% compliance and then the audits will be performed quarterly. See exhibit #G159	

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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 policy review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral as required by agency policy in 2 of 13 clinical records reviewed with the potential to affect all new patients. (# 12 and 13)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 13, start of care 11/1/12, evidenced a verbal order dated 10/29/12 to provide skilled nurse services once a week to address diagnosis hypertension and pulmonary disease. The record failed to evidence an initial assessment was completed within 48 hours of the referral or documentation to explain why the initial visit was late. 2. The policy titled "Evaluation / Admission Process" dated 4/14/11 stated, "The RN or therapist should contact the patient / and or caregivers to make arrangements for an evaluation visit. The evaluation visit should be scheduled 	N0540	<p>All Field Clinicians and Administrative staff were in-serviced on policy "Evaluation/Admission Process" 4.1.0, dated 4/14/2011, on 1/3/2013 by the Administrator. New staff will receive training as part of their orientation. Referral can be initiated by any staff member and should be documented on exhibit #G171 "Skilled Client Referral". Once the referral process has been initiated, the Clinical Support Coordinators will gather additional information needed such as client demographics, payor information, and clinical information. This will be provided to the appropriate RN who will, within 48hrs of referral or hospital discharge, schedule an evaluation and possible initial assessment or document why assessment/care could not be initiated. The Performance Improvement Coordinator and/or designee will review 100% of the referral records on a monthly basis to ensure compliance. When 100% compliance has been achieved the audits will be performed on a quarterly basis. 100% of all new referral records will continue to be reviewed. The</p>	01/03/2013			

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	<p>within forty - eight (48) hours of referral."</p> <p>3. Clinical record #12, start of care 10/8/12, evidenced a referral to home care dated 9/13/12 and a comprehensive assessment on 10/11/12. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs.</p> <p>On 12/31/12 at 5:08 PM, the director of nursing indicated the initial assessment had not been completed in 48 hours.</p>		Administrator is responsible for monitoring the Performance Improvement Coordinator and ensuring that reviews are completed. See exhibit #G171		

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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 policy review, and interview, the agency failed to ensure the home health aide had completed a competency evaluation program for 4 of 4 home health files reviewed with the potential to affect all the patients receiving home health aide services. (E, F, G, and H)</p> <p>The findings include:</p> <p>1. Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse.</p> <p>Clinical record # 1, start of care 9/18/12 included documentation employees E provided services on</p>	N0596	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency</p>	02/05/2013

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	<p>November, 18, 23, and 24, 2012.</p> <p>2. Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions,</p>		<p>evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only.</p> <p>On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information.</p> <p>Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency</p>				

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	<p>basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that</p>		<p>evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register.</p> <p>Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>		

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	<p>was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations.</p>			

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NAME OF PROVIDER OR SUPPLIER ADDUS HEALTHCARE (INDIANA) INC	STREET ADDRESS, CITY, STATE, ZIP CODE 674 N 36TH ST LAFAYETTE, IN 47905
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	<p>Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."</p>			

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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. Based on personnel record and policy review and interview, the agency failed to ensure home health aides were entered on and in good standing on the state aide registry for 3 of 4 aide files reviewed (E, F, and H) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel record E, date of hire 9/26/12, failed to evidence the employee was entered on and in good standing on the state aide registry. 2. Personnel record F, date of hire 11/15/12, failed to evidence the employee was entered on and in good standing on the state aide registry. 3. Personnel record H, date of hire 11/15/12, failed to evidence the employee was entered on and in good standing on the state aide registry. 4. The policy titled "Employment Procedures" dated 6/15/11, stated, "Home Health Aides should be asked for a copy of their certification which will be 	N0597	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section,</p>	02/05/2013			

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	confirmed with the state in compliance with regulations." 5. On 12/31/12 at 5:30 PM, the administrator indicated the individuals providing aide services on behalf of the agency were not on the home health registry.		documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only. On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information. Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity. Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that		

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			Home Health Aides are active and in good standing on the state register. Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.		

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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 record, clinical record, and policy review and interview the agency failed to ensure documentation evidenced the home health aide had completed a competency evaluation program prior to providing services for 4 of 4 home health aide files reviewed (D, E, F, and H) and 3 of 4 home health aide were entered on and in good standing on the state aide registry (E, F, and H) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Personnel record E, date of hire and first patient contact 9/26/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 9/26/12. The document was signed by the employee; there was not a signature of a registered nurse. The file failed to evidence the aide was listed on and in good standing on the state aide registry</p> <p>Clinical record # 1, start of care 9/18/12 included documentation</p>	N0598	<p>Administrator/Agency Director is responsible for maintaining the standard. Administrator/Agency Director has read and in-serviced January 3 rd , 2013 Field Clinicians on policies, "Home Health Aide Services" 4.9.0, dated 6/4/2011, "Home Health Aide Inservice Education" 4.10.0, dated 4/14/2011, "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, and "Home Health Aide Competency" 4.12.0, dated 4/14/2011. Correction has been made to procedures to comply with 42 CFR 484.36 to ensure; the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care, the home health aide successfully completed a competency evaluation program performed by a registered nurse, the home health aide successfully completed a competency evaluation program that was performed by a registered nurse and a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x),</p>	02/05/2013			

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	<p>employees E provided services on November, 18, 23, and 24, 2012.</p> <p>2. Personnel record F, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake. The file failed to evidence the aide was listed on and in good standing on the state aide registry</p> <p>Clinical record # 2, start of care 11/15/12, included documentation employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012.</p> <p>3. Personnel record G, date of hire 8/3/12 and first patient contact 8/23/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 8/23/12. The document was not of</p>		<p>and (xi) of this section, documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care, the registered nurse provided care instructions for the home health aide, and the registered nurse conducted a supervisory visit at least every 14 days for skilled patients with aide services and/or every 30 days for patients with aide services only.</p> <p>On January 7 th , 2013 the Administrator/Agency Director was informed that Addus Healthcare (Indiana), Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 7, 2013, to January 7, 2015, due to being found to be out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.11: Release of Patient Identifiable OASIS Information.</p> <p>Administrator/Agency Director shall hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for employed Home Health Aides to attend a training and competency evaluation or competency evaluation program provided by another entity.</p>		

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	<p>sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake.</p> <p>Clinical record # 1, start of care 9/18/12, included documentation employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012.</p> <p>4. Personnel record H, date of hire and first patient contact 11/15/12, evidenced a document titled "Addus Health Aide / Nurse Aide Competency and Skill Observation Checklist" dated 11/15/12. The document was not of sufficient scope to ensure competency related to basic infection control procedures and universal precautions, basic elements of body functioning, body mechanics, range of motion, changes in body function that must be reported to an aide's supervisor, recognizing emergencies and knowledge of emergency procedures, and adequate nutrition and fluid intake. The file failed to evidence the aide was listed on and in</p>		<p>Administrator/Agency Director shall maintain records of Home Health Aide Training and Competency and ensure that Home Health Aides are active and in good standing on the state register.</p> <p>Administrator/Agency Director shall audit all of Home Health Aide personnel records by 2/5/2013 and Home Health Aides found to not be in compliance shall not be allowed patient contact. Administrator/Agency Director shall audit all of Home Health Aide personnel records monthly thereafter until 100% percent are within compliance. Home Health Aide personnel records shall all be reviewed quarterly thereafter.</p>				

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	<p>good standing on the state aide registry</p> <p>During a home visit on 12/31/12 at 10 AM, employee C indicated the patient had a dislocation of the right shoulder that was painful, and the patient had little use of the extremity. The caregiver indicated employee H provided "some" range of motion during visits and the dislocation occurred about one year ago. Employee H indicated she provided and completed bed baths for the patient, transferred the patient between surfaces via a Hoyer lift, emptied the urinary drainage bag, and demonstrated on herself that the patient could raise her right extremity to ninety degrees.</p> <p>5. On December 28, 2012 at 10 AM, employee C, a registered nurse, indicated she was not aware all the required skills that were to be demonstrated by the individuals as part of the competency. She indicated the individuals were evaluated in the homes of the patients in which they were to provide future visits to provide services on behalf of the agency and she observed the individual perform the tasks required for the assigned patient. She further indicated to not be aware the individual was to perform a bed bath on a real person.</p> <p>6. The policy titled "Home Health Aide</p>						

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	<p>Competency Evaluation" dated 4/14/11 stated, "Purpose: To evaluate Home Health Aide knowledge of basic concepts that are needed to give safe and effective care in compliance with regulations. Policy: All newly hired and reactivating Home Health aides are expected to complete and pass knowledge based written exams with a score of 75 % and demonstrate satisfactory performance of personal care skills prior to ant patient assignment. ... Evaluation of demonstrated personal care skills conducted on a patient will be conducted by a registered nurse and include: a. Reading and recording temperature, pulse, and respiration, b. Sponge, tub, shower bath, c. Nail and skin care, d. Oral hygiene, e. Toileting and elimination, f. Safe transfer techniques and ambulation, g. Basic infection control procedures, and h. Normal range of motion and positioning. ... The evaluation of the aide's competence must be carefully documented, specifying the exact tasks the aide was evaluated as competent to perform."</p> <p>7. The policy titled "Employment Procedures" dated 6/15/11, stated, "Home Health Aides should be asked for a copy of their certification which will be confirmed with the state in compliance with regulations."</p>				

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	8. On 12/31/12 at 5:30 PM, the administrator indicated the individuals providing aide services on behalf of the agency were not on the home health registry.			

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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 policy review and interview, the agency failed to ensure the registered nurse conducted a supervisory visit at least every 30 days for 5 of 8 (1, 2, 5, 10, and 12) clinical records reviewed where aide services were provided for a minimum of 30 days with the potential to affect all patients receiving aide services.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 9/18/12, included documentation employee E provided services on November, 18, 23, and 24, 2012; employee G provided services on November 16, 19, 20, 21, 26, 27, 28, 29, and 30 and December 3, 5, 6, 10., 11, 12, 13, and 14, 2012; employee I provided services on December 1, 2, 8, 9, and 15, 2012; and employee J provided services on November 19, 2012. The clinical record failed to evidence a supervisory visit was conducted at least every 30 days.</p>	N0606	<p>The Administrator/ Agency Director in-serviced, on 1/3/2013, the Field Clinicians on the requirement of Home Health Aide (HHA) Supervisory visits. Per policy "Home Health Aide Supervision" 4.11.0, dated 6/7/2011, HHA Supervisory visits must be conducted, at a minimum of every 14 days, where skilled care and home health aide services are provided, and every 30 days for patients who receive home health aide services only. Field Clinicians will document these supervisory visits on the "Nursing Visit Note" for skilled visits and hha only visits. In addition field clinicians will also document this visit on the Home Health Aide Supervision Note. The Administrative/Agency Director will review and discuss with all new field clinician employee orientations and document confirmation on the skills checklist.</p> <p>The clinical support coordinator will, on a weekly basis, track Home Health Aide (HHA) supervisory visits utilizing the</p>	01/03/2013			

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	<p>On 12/27/12 at 3 PM, employee C indicated there were no other visits by the registered nurse between 11/16/12 and 12/21/12.</p> <p>2. Clinical record # 2, start of care 11/15/12 included a plan of care dated 11/15/12 with orders for skilled nursing once a month for 3 months and aide services five times a week for 10 weeks. Documentation evidenced employee F provided services on November 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and December 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2012. The clinical record failed to evidence a supervisory visit was conducted at least every 30 days.</p> <p>On 12/28/12 at 4:25 PM, employee A indicated there were not any unfilled visit notes.</p> <p>3. Clinical record 5, start of care 11/16/12, included a plan of care for the certification period 11/16/12 through 1/14/12 with orders for skilled nursing once a month and aide visits 3 times a week. The clinical record identified aide services were provided on November 16, 18, 19, 21, 23, 26, 28, and 30 and December 5, 7, 10, and 12, 2012 from employees C, H, I, and K. The clinical record failed to evidence a supervisory visit was made every at least 30 days.</p>		<p>current calendar tracking form used for monitoring frequencies and durations. Any discrepancies will be reported to the Administrator/Agency Director. Failure to do so will result in disciplinary action.</p> <p>The Administrator/ Agency Director will be responsible for overseeing that the clinical support coordinator performs the above task and will monitor these corrective actions to ensure HHA supervisory visits are timely.</p> <p>The Performance Improvement Coordinator will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved, and then the audits will be performed quarterly.</p> <p>See exhibit #G229</p>				

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	<p>The record evidenced only 2 skilled visits, one dated 11/16/12 and one dated 12/21/12.</p> <p>4. Clinical record # 10, start of care 8/21/12, evidenced a plan of care dated 10/20/12 with orders for skilled nursing once a month and aide services 2 times a week for eight weeks. The record evidenced aide services were provided on October 23, 26, and 29 and November 16, 19, 23, and 26, 2012. The clinical record evidenced a supervisory visit was made on 10/16/12 and 11/29/12.</p> <p>5. The policy titled "Home Health Aide Services" dated 6/7/11 stated, "A registered nurse or therapist a supervisory visit at least every two weeks when skilled services are being provided and every 60 - 62 (sixty - sixty - two) days when no skilled services are ordered, or in accordance with applicable state regulations or third party payer guidelines."</p> <p>6. Clinical record #12 included physician orders dated 10/8/12 for the skilled nurse to supervise the home health aide two times a month for 9 weeks. The record failed to evidence the registered nurse had made any supervisory visits after 11/10/12 despite aide visits which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157472	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/31/2012
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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>occurred on 11/14/12, 11/15/12, 11/16/12, 11/21/12, 11/23/12, 11/28/12, 11/29/12, 11/30/12, 12/4/12, 12/5/12, and 12/6/12.</p> <p>On 12/31/12 at 4:40 PM, Employee A indicated no RN supervisory visits occurred between 11/10/12 - 12/6/12.</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 policy review, the agency failed to ensure the record contained a discharge summary for 4 of 4 discharged records reviewed (# 9, 10, 11, and 13) with the potential to affect all patients who are discharged.</p> <p>The findings include:</p> <p>1. Clinical record # 9, start of care 8/24/12 and discharge 11/26/12, failed to evidence a discharge summary.</p> <p>2. Clinical record # 10, start of care 8/21/12 and discharge date 12//14/12, failed to evidence a discharge summary.</p>	N0608	The Administrator/Agency Director will ensure the standard is met. The Administrator/Agency Director will review all completed discharge packets submitted by the field clinicians for the inclusion of the discharge summary, and delegate the responsibility to the Clinical Support Coordinator to fax the discharge summary to the physician following the review, and stamp "Faxed" with date on the report as a confirmation. Deficiency had been identified through our internal audit on January 2 nd and 3 rd , 2013, and the Clinical Support Coordinator and Field Clinicians were trained, January 3	01/03/2013			

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	<p>3. Clinical record 11, start of care 9/4/12, evidenced a transfer / discharge assessment was completed dated 11/2/12. The record failed to evidence a discharge summary.</p> <p>4. Clinical record 13, start of care 11/1/12,evidenced a transfer / discharge assessment was completed dated 11/2/12. The record failed to evidence a discharge summary.</p> <p>5. The undated policy titled "Clinical Record Content and Maintenance" states, "The client's clinical record will contain ... Discharge Summary."</p>		<p>rd , 2013, on policies; "Medical Supervision" 4.2.0, dated 5/3/2011, "Physician's Plan of Care/Treatment and Notification of Patient's Change in Condition" 4.3.0, dated 4/18/2011 and "Patient Plan of Care" 4.4.0, dated 6/7/2011 and this procedure was implemented at that time.</p> <p>The Performance Improvement Coordinator or Designee will review 25% of the medical records to ensure compliance. This will be done on a monthly basis until 100% compliance is achieved. Then the audits will be performed quarterly.</p>		