

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157652	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/29/2013
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NAME OF PROVIDER OR SUPPLIER  HOME HEALTH CARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 W 2ND STREET MARION, IN 46952
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N000000	<p>This visit was a state home health complaint investigation.</p> <p>Complaint IN00131260, IN00132194, IN00132319, IN00132066, and IN00132402- Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Dates: July 24, July 25, July 26, and July 29, 2013</p> <p>Facility #: 012169</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">August 9, 2013</p>	N000000		

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

TITLE

(X6) DATE

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

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N000454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to:</p> <ul style="list-style-type: none"> <li>(1) respond to an emergency;</li> <li>(2) provide guidance to staff;</li> <li>(3) answer questions; and</li> <li>(4) resolve issues;</li> </ul> <p>within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on personnel file review, policy review, and staff interview, the agency failed to ensure there was an alternate director of nursing for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 7/24/13 at 2:40 PM, employee B (director of nursing) indicated she was on vacation in Africa from 6/28/13 to 7/16/13 and employee G is the alternate director of nursing and was available during the absence.</li> </ol> <p>A. Personnel file for employee B contained a job description dated 6/2/09 titled "Director of Nursing/Alternate job Description" which states, "Primary Purpose: The primary purpose of the Director of Nursing is to plan, direct,</p>	N000454	Administration Management failed to ensure there was an alternate director of nursing. Failed to have job description for alternate director of nursing. New alternate director of nursing appointed. Oriented to responsibilities. ISDH notified of staff changes and new alternate director of nursing qualifications to meet these requirements. Job description for Alternate Director of nursing reviewed and signed on August 16, 2013. Human Resources or desgnee will audit all employee files for job description, and will then audit 10% of all employee files each month for compliance.	08/16/2013			

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	<p>coordinate, and supervise the delivery of health care. The director of nursing is to manage the nursing department of the home health agency. Performance Responsibilities: The director of nursing will work with our staff, patients, families, physicians and other professionals to ensure that our patients receive the best possible care. The director of nursing will: 1. Supervise the nursing department in the daily operations of the HHA. ... 17. Ensure that a qualified person is authorized in writing to act in the director of nursing's absence."</p> <p>B. Personnel file for employee G contained a job description dated 9/26/12 titled "(RN) Registered Nurse/ Case Manager" but failed to evidence a job description for alternate director of nursing.</p> <p>2. On 7/24/13 at 3:52 PM, a telephone interview with employee G (alternate director of nursing) was conducted. The employee indicated her title at the agency was Registered Nurse/Case Manager but is currently employed elsewhere and has not worked for the agency in months. Employee G indicated she has never signed a job description for the title of Alternate Director of Nursing and was not aware that was her current title at the</p>			

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	<p>agency.</p> <p>3. On 7/29/13 at 11:40 AM, employee B indicated employee G was not notified of her absence during 6/28/13 to 7/16/13 and was not available during that time of the director of nursing's absence.</p> <p>4. Agency policy titled "Clinical Supervision" with an effective date as 1/1/13 states, "POLICY Skilled nursing and other therapeutic services are provided under the supervision of a Registered Nurse. The Director of Nursing or a designated qualified Registered Nurse will be available to provide ongoing supervision during the operating hours of the Agency ... SPECIAL INSTRUCTIONS ... 5. The Nursing Supervisor or similarly qualified alternate shall be available at all times during operating hours."</p>			

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N000458	<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.</p> <p>Based on the Indiana State Department of Health (ISDH) documentation, agency policy review, document review, personnel file review, and interview, the agency failed to follow written policies regarding personnel and failed to ensure personnel files contained job descriptions in 3 of 8 personnel files reviewed. (employees A, B, and G)</p> <p>Findings include:</p> <p>1. Agency policy titled "Criminal Background Checks" with an effective date of 1/1/13 states, "POLICY Agency requires background screening to be completed on all final candidates for</p>	N000458	Administration management failed to follow written policies regarding personnel and failed to ensure personnel files contained job descriptions in 3 of 8 personnel files reviewed. Employee A Employee B Employee C All present employees will have a national criminal history check completed to ensure they meet this policy requirement. Any employee who does not meet this requirement will be terminated. Online application process update with the question " Have you lived out of state in the last 2 years?" Any employee who answers yes to this question will automatically have a national criminal history completed. All new candidates that are consider for employment	08/28/2013			

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	<p>employment. ... PURPOSE To provide increased safety for clients of the Agency. To reduce risk to the Agency. SPECIAL INSTRUCTIONS ... 2. The employee will also be required to complete the documentation required to obtain a criminal background study. The criminal background check includes a state and national criminal history check ... 8. The following crimes disqualify persons for employment: ... n. Crimes related to prohibited drugs."</p> <p>2. Personnel file for employee A, evidenced a document signed by the employee and dated 1/1/11 titled "Home Healthcare Associates, inc. <u>Application for Employment</u> Pre-employment Questionnaire Equal" that states, "Date you can Start 1/11/11" and a document titled "Home Health Care Associates, Inc. <u>Orientation Checklist</u> " stating, "Employee Name: [employee A] Position: Assistant Administrator Date: 5/28/11 ... I have read and understand my roles and responsibilities as a new employee of the Home Health Care Associates, Inc. and I agree to accept and carry out those responsibilities to the best of my abilities and other assigned tasks. ... Employee Name: [employee A] Employee Signature: [employee A signature] Date signed: 5/28/2011 Date of Hire: 5/26/2011." The file contained a</p>		<p>must meet all company requirements. All employee personnel files will be audited to verify they have required job description for the position they are performing. Employee A has been terminated from the agency. A new administrator has been appointed to this position effective July 29, 2013, and the ISDH was informed of this change on August 1, 2013. Human Resources or desgreee will audit all employee files for job description, and will then audit 10% of all employee files each month for compliance. The administrator will oversee human resources and ensure all audits are completed appropriately.</p>				

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	<p>job description dated 11/1/10 titled "Administrator / Alternate job description" and an undated job description titled "Administrator." The record failed to evidence a national criminal history check was completed on the employee.</p> <p>A. On 7/24/13 at 12:53 PM, employee I presented surveyor with a document titled "Official CBR Criminal Report" dated 7/24/13 with employee A being person named as investigated. The document states, "RECORD DETAILS Florida Criminal IDENTITY ... CASES ... OFFENSES Description: Opium-Poss less/10 grams Disposition: Description: Florida DOC Supervision Date: 2010-12-17 ... CHARGES Description: OPIUM-POSS LESS/10 GRAMS Description: POSS. CONTROL SUBS/OTHER." Employee I indicated the administrator was incarcerated at time of survey and had a criminal history of felony, drug-related charges.</p> <p>B. On 7/24/13 at 2:40 PM, employee B (owner / alternate administrator / director of nursing) indicated employee A resided in the state of Florida in 2010, prior to employment with the agency. She indicated being aware the employee had a criminal history at the time of hire.</p>			
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	<p>2. ISDH information listed employee B as Alternate Administrator.</p> <p>A. Personnel file for employee B failed to evidence a job description for alternate administrator.</p> <p>B. On 7/24/13 at 11:30 AM, employee B indicated her title at the agency included alternate administrator.</p> <p>3. ISDH information listed employee G as alternate director of nursing.</p> <p>A. Personnel file for employee G failed to evidence a job description for alternate director of nursing.</p> <p>B. On 7/24/13 at 3:52 PM, employee G indicated her job description at the agency was registered nurse / case manager and she had never signed a job description for alternate director of nursing.</p>				

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N000484	<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, policy review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outline in the plan of care in 1 of 4 clinical records reviewed with the potential to affect all the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported the plan of care.</p> <p>On 7/26/13 at at 4:30 PM, employee B (director of nursing) indicated there was no communication between personnel furnishing services for this patient.</p>	N000484	<p>QA and performance failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts coordinated effectively and supported objectives outlined in the plan of care in 1 of 4 clinical records reviewed. Policy for coordination of client services will be reviewed by all employees who provide skilled care and home health services to our clients. Care conferences will be conducted by the DON or designee Q month with documentation and changes every month and as needed. These conferences will be noted in each clients chart reviewing decisions and changes made during review, and reviewed with case managers during weekly nursing meetings.</p>	08/26/2013	

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	<p>2. Agency policy titled "Coordination of Client Services" with an effective date as 1/1/13 states, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. ...</p> <p>SPECIAL INSTRUCTIONS 1. Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care."</p>			

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N000494	<p>410 IAC 17-12-3(a)(1)&amp;(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, agency policy review, and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient or doing the initial evaluation visit before the initiation of treatment in 1 of 4 records reviewed with the potential to affect all the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care date 6/14/13, evidenced a document titled "Comprehensive Adult Assessment" dated 6/14/13 and entered electronically by employee F (registered nurse).</p> <p>The record also evidenced a document</p>	N000494	All skilled providers will be in-serviced on the policy Client Admission Process by September 23, 2013 by the DON or designee, with emphasis on the Start of Care date. All current charts will be audited to ensure that they have the appropriate SOC date. The DON or designee will review every new admission with 72 hours for QA of dated material. DON or designee to accompany each case manager on a SOC for verification of knowledge or training with check off.	08/28/2013			

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	<p>titled "Home Health Care Associates, Inc. ADMISSION SERVICE AGREEMENT" signed by the patient with a date as 6/17/13 that states, "Consent for care and service I hereby consent and authorize Home Healthcare Associates, INC (Agency) and its agents and associates to provide care and service to me in my home. The care provided is prescribed by my physician under a physician's home health plan of care and provided per agency policy... I have received &amp; understand the explanation of the services to be provided to me by the Agency. I understand the disciplines, proposed visit frequency, and the anticipated outcomes of care and treatment. I have been involved in the development of the plan of care and am aware of how changes will be made to the plan of care as needed.</p> <p>ACKNOWLEDGEMENT OF INFORMATION I have received verbal and written information on the following: Advance Directives ... Patient's Rights and Responsibilities ... Organization's Complaint/Grievance process and the Indiana State Department of Health Toll Free Complaint Hotline number ... CMS statement of patient privacy rights and privacy act statement ... Notice of privacy practices ... Disclosure of information policy ... Infection Control. This Admission Agreement is applicable to this admission to the organization ..."</p>				

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	<p>2. Agency policy titled "Client Admission Process" with an effective date as 1/1/3013 states, "PURPOSE To establish a consistent admission process for all clients admitted to Agency ... SPECIAL INSTRUCTIONS ... 10. The admission professional will: a. Verify all the information on the intake form with the client/caregiver. b. Provide the client with a copy of their privacy rights and the Notice of privacy practices, and obtain consent to use and disclose protected health information for treatment, payment and health care operations. c. Provide the client/caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the Statement of Privacy Rights related to the collection and transmission of personal health care information. ... i. Obtain the clients's signature on the Service Agreement, Home Care Bill of Rights, and other forms required by the agency."</p> <p>3. On 7/26/13 at 2:41 PM, employee B (alternate administrator/director of nursing) indicated the document titled "Comprehensive Adult Assessment" dated 6/14/13 was the initial and comprehensive assessments combined and the admission service agreement</p>						

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	should have been signed by the patient on 6/14/13 which was the start of care date.			

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N000505	<p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on clinical record review and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 1 of 4 patient records reviewed with the potential to affect all the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. On 7/26/13 at 4:40 PM, family member who assists in home care for patient #1 indicated patient had recently received placement of a Foley catheter but no one let the patient or family know when it would be removed and no education on Foley Catheter was provided. The family member indicated that during a skilled nursing (SN) visit from employee L on 7/25/13, the patient</p>	N000505	Failed to ensure the patient was informed in advance of any changes in the care to be furnished. Failed to evidence the patient and family had been informed of the increase in skilled nursing visits for wound care upon receipt of physicians orders on 7/16/13 and 7/18/13. Failed to evidence patient and family education for foley catheter use or expected time of use at time of placement on 7/16/13. All skilled care providers will be in- serviced on the policy Plan of Care with special attention to notify client and or caregiver of all changes in care in a timely manner. Will emphasize the importance of providing education and reviewing skilled abilities for follow up care that client or caregiver will provide. Family/patient will will sign	08/28/2013			

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NAME OF PROVIDER OR SUPPLIER  HOME HEALTH CARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 W 2ND STREET MARION, IN 46952
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	<p>and family was informed of an increase in skilled nurse visits for wound care.</p> <p>2 Clinical record #1 contained a physicians plan of care with a certification period of 6/14/13 to 8/12/13 with orders for skilled nursing visit frequency "1 x q [every] 3 days for wound txs [treatment] and fentanyl patch change, 1 x q week for med sets [medication set ups], 1 x q 2 weeks for sup visits ..." and integumentary interventions as "Assess perform instruct pt [patient]/cg [caregiver] wound care as follows: xeroform et [and] bactroban to open areas on L [left] heel et coccyx, cover with tegaderm q 3 days et prn until healed, pt/cg wound care will be performed by : SN ..."</p> <p>A. The record evidenced a physicians order dated 7/16/13 which states, "Increase in SN visits to 1x every other day for tx to L heel et coccyx area pressure sores." An order dated 7/17/13 stating, "Order for catheter 22 fr 30 cc to be changed 1 x mth [month] et prn." An order dated 7/18/13 stating, "Increase sn hours to 1x q other day for dressing changes to left heel et 2 x dly [daily] x 7 days for coccyx dressing changes. Pending PA [prior authorization]. until wound heals."</p>		<p>paperwork acknowledging they received education. Financial agreement will also be updated with frequency of visits and placed in patient's company folder in the home. Agency will provide educational literature to client and caregiver for any new procedure they will be assisting with. A signature sheet will confirm this information was provided and that client and caregiver understood information. The case manager will notify the DON or designee of any changes in skill needs from their caseload every day with an email shift report. All cases will be reviewed during weekly nursing meetings. The DON or designee will be run a daily with a daily order report to ensure that family/client were notified of any new orders and that education was provided.</p>	

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	<p>B. The record failed to evidence the patient and family had been informed of the increase in skilled nursing visits for wound care upon receipt of physicians orders dated 7/16/13 and 7/18/13 and failed to evidence patient/family education for Foley Catheter use or expected time of use at time of placement on 7/16/13.</p> <p>3. On 7/29/13 at 11:16 AM, employee L (RN-Case manager) indicated she was aware of the 7/18/13 physician's order to increase skilled nursing visits for dressing changes and the patient and family was made aware of this change on 7/25/13.</p> <p>4. Agency policy titled "Plan of Care" with an effective date as 1/1/13 states, "Purpose to reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... Special Instructions ... 7. The client, therapist, and other agency personnel shall participate in developing the Plan of Care. The client shall be informed of any changes in the Plan of Care."</p>				

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N000506	<p>410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on clinical record review and interview, the agency failed to ensure the patient was informed of any changes in the care to be furnished in 1 of 4 patient records reviewed with the potential to affect all the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. On 7/26/13 at 4:40 PM, family member who assists in home care for patient #1 indicated patient had recently received placement of a Foley catheter but no one let the patient or family know when it would be removed and no education on Foley Catheter was provided. The family member indicated that during a skilled nursing (SN) visit from employee L on 7/25/13, the patient and family was informed of an increase in skilled nurse visits for wound care.</p> <p>2 Clinical record #1 contained a</p>	N000506	Failed to ensure the patient was informed of and changes in the care to be furnished in 1 of 4 patients records reviewed. Failed to evidence the patient and family had been informed of the increase in skilled nursing visits for wound care upon receipt of physicians orders dated 7/16/13 and 7/18/13. All skilled care providers will be in- serviced on the policy Plan of Care with special attention to notify client and or caregiver of all changes in care in a timely manner. Will emphasize the importance of providing education and reviewing skilled abilities for follow up care that client or caregiver will provide. Agency will provide educational literature to client and caregiver for any new procedure they will be assisting with. A signature sheet will confirm this information was provided and that client and caregiver understood information. The case manager will notify the DON or designee of any changes	08/28/2013	

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	<p>physicians plan of care with a certification period of 6/14/13 to 8/12/13 with orders for skilled nursing visit frequency "1 x q [every] 3 days for wound txs [treatment] and fentanyl patch change, 1 x q week for med sets [medication set ups], 1 x q 2 weeks for sup visits ..." and integumentary interventions as "Assess perform instruct pt [patient]/cg [caregiver] wound care as follows: xeroform et [and] bactroban to open areas on L [left] heel et coccyx, cover with tegaderm q 3 days et prn until healed, pt/cg wound care will be performed by : SN ..."</p> <p>A. The record evidenced a physicians order dated 7/16/13 which states, "Increase in SN visits to 1x every other day for tx to L heel et coccyx area pressure sores." An order dated 7/17/13 stating, "Order for catheter 22 fr 30 cc to be changed 1 x mth [month] et prn." An order dated 7/18/13 stating, "Increase sn hours to 1x q other day for dressing changes to left heel et 2 x dly [daily] x 7 days for coccyx dressing changes. Pending PA [prior authorization]. until wound heals."</p> <p>B. The record failed to evidence the patient and family had been informed of the increase in skilled nursing visits for wound care upon receipt of physicians</p>		<p>in skill needs from their caseload every day with an emailed shift report. All cases will be reviewed during weekly nursing meetings. The DON or designee will be run a daily with a daily order report to ensure that family/client were notified of any new orders and that education was provided.</p>				

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	<p>orders dated 7/16/13 and 7/18/13 and failed to evidence patient/family education for Foley Catheter use or expected time of use at time of placement on 7/16/13.</p> <p>3. On 7/29/13 at 11:16 AM, employee L (RN-Case manager) indicated she was aware of the 7/18/13 physician's order to increase skilled nursing visits for dressing changes and the patient and family was made aware of this change on 7/25/13.</p> <p>4. Agency policy titled "Plan of Care" with an effective date as 1/1/13 states, "Purpose to reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... Special Instructions ... 7. The client, therapist, and other agency personnel shall participate in developing the Plan of Care. The client shall be informed of any changes in the Plan of Care."</p>				

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N000514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on agency document review, policy review, and interview, the agency failed to ensure complaints were investigated regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA in 1 of 1 agency complaint log reviews with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. On 7/29/13 at 1:37 PM, review of agency complaint/incident log evidenced a document dated 7/17/13 titled "Home Health Care Associates, Inc. Incident Report-Follow Up" stating, "Client Name: [patient #1] Date and Time of incident: July 16, 2013 7 PM Date and Time of Report: July 17th, 2013 10 AM</p>	N000514	Failed to ensure complaints were investigated. All staff will be in-serviced on Incident Reporting. All incidents will be reviewed by Case Manager, DON or designee in weekly staff meeting for follow up with investigation and outcome. All incidents will be tracked in an Incident Reporting Log. All nursing staff will be in-serviced by DON or designee, on what incidents require immediate action and reporting to APS or ISDH.	08/28/2013	

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	<p>FOLLOW UP Received a phone call from RN [employee F] that client is missing FENT patches. She had 9 patches left on last visit and during this visit there was only 4 remaining. Administrator notified by phone on the 16th and the scheduling department was notified to take accused [employee N] out of home permanently." The agency complaint/incident log failed to evidence documentation of investigation of the complaint.</p> <p>2. On 7/29/13 at 1:50 PM, employee K indicated the complaint was given to employee A (administrator) and he is unsure if there was an investigation on this complaint but does affirm the home health aide, employee N, was terminated.</p> <p>3. Agency policy with an effective date of 1/1/13 titled "Incident Reporting POLICY The incident Report Form is to be completed whenever there is an incident involving a staff member or a client. An incident is defined as any occurrence that involves an employee, client or family member that is not consistent with regular routine. ... Staff is expected to follow agency policies to prevent incidents and seek assistance immediately in the event of an incident. The reporting of incidents and the investigation are part of the agency's</p>						

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	performance improvement program. ... SPECIAL INSTRUCTIONS 1. Agency will document and report all incidents that deviate from routine agency operations ... 2. Incidents to be reported include, but are not limited to: a. Missing or damaged property...."			

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N000520	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure there were enough staff to provide treatments to patients as ordered on the plan of care in 2 of 4 patient records reviewed creating the potential to affect all the agency's patients. (#1 and 3)</p> <p>Findings include:</p> <p>1. Clinical record #1 had a start of care date of 6/14/13 and included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 that states, "SN [skilled nurse] visit frequency ... : 1 x [time] q [every] 3 days for wound txs [treatments] and Fentanyl patch change ... Assess Perform Instruct Pt [patient] / Cg [caregiver] wound care as follows: xeroform et [and] bactroban to open areas on L [left] heel et [and] coccyx, cover with tegaderm q [every] 3 days et [and] prn [as needed] until healed, Pt/Cg Wound care will be performed by: SN [skilled nurse]." The record also included a comprehensive assessment performed on 6/14/13 by employee F</p>	N000520	Failed to ensure there were enough staff to provide treatments to patients as ordered on plan of care in 2 of 4 patient records. Failed to evidence wound measurements. All skilled nursing staff will be in-serviced regarding the policy on Pressure Ulcer Assessment and Staging of Pressure Ulcers. All skilled nursing staff will be in-serviced on the policy regarding Skilled Nursing Services. All skilled care providers will be in-serviced on Services Provided including pressure wound care, their responsibilities, and how to provide care in the event of an emergency. All staff providing skilled care will review policies relating to medical management of pressure ulcers. Each employee will be tested and skills checks performed by the DON or designee as of September 23, 2013 for demonstration of skills. Contacting other agencies to negotiating a contract to be a back up staff providers on an as needed basis, to assure continuous care. All potential missed visits will be reported to the DON immediately to ensure needs are met. DON or alternate	08/28/2013			

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	<p>which states under "<i>INTEGUMENTARY STATUS ... TYPE</i> 1. Pressure Ulcer <i>LOCATION</i> L heel <i>SIZE</i> L 2" W 1" cm <i>WOUND BED</i> color: white tissue: Pale <i>SURROUNDING SKIN</i> Pink <i>TYPE</i> 2. Pressure Ulcer <i>LOCATION</i> Coccyx <i>SIZE</i> L 2" W 1" D 1 1/2" cm <i>WOUND BED</i> Color: Pink Tissue: Pale <i>SURROUNDING SKIN</i> Pink."</p> <p>A. The record contained a nursing visit record document dated 7/2/13 by employee C (Registered Nurse) evidencing wound care performed and Fentanyl patch change with skin assessment as follows; "<i>SKIN WOUND #1 LOCATION</i> heal of left foot L .5 W .5 <i>WOUND #2 LOCATION</i> top of coccyx L 1.5 W 1.5 Wound Tx performed this visit per POC [plan of care]."</p> <p>B. The record failed to evidence wound care or Fentanyl patch change was performed again until 7/10/13 at which time employee F (registered nurse) documented the following skin assessment, "<i>SKIN WOUND #1 LOCATION</i> L heel L 2.4 W 2.1 <i>DRAINAGE Amt</i> None <i>WOUND BED Color</i> Pink <i>Pain</i> Yes <i>WOUND #2 LOCATION</i> Coccyx Wound Tx [treatment] performed this visit per POC."</p>		director of nursing on call 24-7. DON will mandate skilled nurse to provide care/Tx or DON or alternate director of nursing will go.		

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	<p>On 7/26/13 at 3:39 PM, employee B indicated there should have been a skilled nursing visit made July 5, 2013, but it was missed because staff availability.</p> <p>C. The record contained a nursing visit record dated 7/16/13 by employee F evidencing wound care performed and Fentanyl patch change. The nursing visit record document included skin assessment as follows; "<u>SKIN WOUND #1 LOCATION</u> L heel <b>DRAINAGE Amt</b> None <b>WOUND #2 LOCATION</b> coccyx <b>DRAINAGE Amt</b> Min <b>Color</b> Blood/mu <b>Odor</b> Yes <b>WOUND BED Color</b> Black Wound Tx performed this visit per POC." The nursing visit record failed to evidence wound measurements but did evidence Foley catheter placement. On 7/26/13 at 4:17 PM, employee B(director of nursing) indicated measurements on all wounds need to be performed at least weekly.</p> <p>1.) Agency policy with an effective date of 1/1/13 titled "Assessment/Staging of Pressure Ulcers" states, "PRESSURE ULCER ASSESSMENT GUIDE In assessing the pressure ulcer, the following parameters should be addressed consistently. -Site, Stage of ulcer, and size of ulcer (include length, width, and depth) .... "</p>			

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	<p>2.) A document dated 7/16/13 titled "Case Conference and Coordination of Care Form" by employee F states, "<i>The above patient was discussed during:</i> Telephone contact Care coordination <b>COORDINATION OF CARE PARTICIPANTS INCLUDED:</b> M.D. S.N. <i>The following areas were discussed:</i> Wound Management <b>Catheter placement needed to heal pressure sore on coccyx area.</b> <b>PATIENT CONCERNS:</b> Pressure sore that are not healing. <b>DISCUSSION:</b> RN case manager spoke to [physician] about concerns that sore on coccyx area is getting worse d/t [due to] pt [patient] constantly being wet from urine leakage. RN asked for an order to catheterize pt for a mth[month] or two in attempt to keep pts skin dry and attempt to heal sore. [physician] agreed and gave verbal order. <b>Patient progress towards goals:</b> Pt agrees to the decision made by RN and MD. <b>Required Follow Up/Responsible Discipline:</b> RN to insert catheter and maintain the care needed."</p> <p>3.) The record evidenced a physicians order dated 7/16/13 to increase skilled nursing visits to 1 time every other day for treatment to the left heel and coccyx area pressure sores and a physicians order dated 7/17/13 for Foley</p>						

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	<p>catheter placement, both electronically signed by employee F.</p> <p>4.) The record evidenced a physicians order dated 7/18/13 by employee L (registered nurse) which states, "Increase sn [skilled nursing] to 1x [time] q [every] other day for dressing changes to left heel et [and] 2x [times] dly [daily] x [times] 7 days for coccyx dressing changes. Pending PA. Until wound heals."</p> <p>5.) On 7/29/13 at 11:16 AM, employee L indicated contacting the wound clinic and scheduling an appointment for the patient to be seen and also contacted the physician and acquiring the order dated 7/18/13 for the increase in skilled nursing visits for wound care. The employee indicates the updated information was then relayed to employee F through voicemail but doesn't remember if she documented it.</p> <p>D. The record failed to evidence a skilled nursing visit was made on 7/18/13.</p> <p>E. A document dated 7/19/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a skilled nursing missed visit due to "Clinician ill and no available substitute clinician <i>Patient's Needs were Met:</i> Authorized contact</p>			

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	<p>person/family/neighbors were contacted to check on patient."</p> <p>F. The record failed to evidence a skilled nursing visit was made on 7/20/13.</p> <p>G. The record failed to evidence a skilled nursing visit was made on 7/21/13.</p> <p>H. The record contained a nursing visit record document dated 7/22/13 by employee F evidencing Fentanyl patch change but no wound assessment or treatment was documented.</p> <p>I. The record failed to evidence a skilled nursing visit was made on 7/23/13.</p> <p>J. A document dated 7/24/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a skilled nursing missed visit due to "Clinician ill and no available substitute clinician <b><i>Patient's Needs were Met:</i></b> Authorized contact person/family/neighbors were contacted to check on patient."</p> <p>K. The record contained a nursing visit record document dated 7/25/13 by employee L evidencing wound care. The document included skin assessment as follows; "<b><i>SKIN WOUND #1</i></b> <b><i>LOCATION</i></b> L heel L 5 cm W 3 cm <b><i>WOUND BED</i></b> Color Red Pain None</p>			

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	<p><b>WOUND #2 LOCATION</b> coccyx L 9 W 8 D .5 <b>DRAINAGE</b> Color Black Odor Yes <b>WOUND BED</b> Color Black Tissue Red Pain No. Wound Tx performed this visit per POC." The record failed to evidence Fentanyl patch change.</p> <p>1.) A document dated 7/25/13 titled "Care Coordination Note" by employee L which states, "<b>Coordination of care with:</b> Aide <b>Communicated via:</b> phone <b>Topic:</b> Coordinate care between disciplines <b>Discussion:</b> Pt was not home for skilled nursing visit to change dressing to coccyx. Pt.'s [family member] was notified and is aware that pt's treatment was not completed as [patient] was not home. Pt's family to change dressing as per order through Monday 7/29/13. <b>Resolution/Follow Up:</b> Sn to change dressing on Monday 7/29/13. <b>Clinical progress:</b> Ongoing/good."</p> <p>2.) On 7/26/13 at 4:32 PM, patient's family member indicated that on 7/25/13, the registered nurse (employee L) informed her of the physicians order to increase skilled nursing visits for dressing changes to wounds and informed the family member that a nurse would not be available to make the visits on 7/26, 7/27, and 7/28/13 and the family would need to provide wound care. The family member also indicated employee L had not</p>						

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	<p>changed the patient's Fentanyl patch on the 7/25/13 visit, the patch is sometimes placed by agency staff with no date of placement labeled, and the agency staff miss visits often, so family has to provide wound care and change the patient's Fentanyl patch.</p> <p>3.) On 7/29/13 at 11:16 AM, employee L indicated the patient's Fentanyl patch was not labeled with the date of application at one skilled nursing visit she made and does not remember the date of that visit but does agree the patch needs dated when applied.</p> <p>L. A document dated 7/26/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made with family to change fentanyl patch et [and] change dressing from 7/26/13 through 7/29/13."</p> <p>M. A document dated 7/27/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made with family to change fentanyl patch et [and] dressing changes."</p>						

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	<p>N. A document dated 7/28/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made for family to change dressings et [and] fentanyl patch through Monday 7/29/13."</p> <p>O. On 7/29/13 at 10:29 AM, telephone interview with patient's power of attorney (POA) indicated the patient was hospitalized on 7/28/13 for weakness and a suspected infection. POA indicated patient's white blood cell count was increased, wounds had worsened, and patient did not receive the skilled nursing services ordered.</p> <p>2. Clinical record #3, start of care 6/11/10, included a plan of care established by the physician for the certification period 5/26/13 to 7/24/13 that states, "SN [skilled nurse] visit frequency ... : 1 v [visit] x [times] 72 hrs [hours] x [times] 9 weeks for patch change ... <b>Medications</b> ... Fentanyl 50 mcg [micrograms] /patch transdermal every 72 hrs [hours] ... <b>60 day summary:</b> Pt is 81 y/o [gender] who lives alone with no available caregiver. Dx [diagnosis] of Renal Failure, COPD, Myalgia, HTN, Incontinence of B/B [bowel and bladder], and Anxiety. ... Pt is a high risk for</p>						

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	<p>hospitalization r/t [related to] inadequate pain management, needs help with ADLs [activities of daily living] and med management, lives alone, confusion, incontinence, and more than 2 secondary Dx. ... SN for fentanyl patch changes every three days ... "</p> <p>The record evidenced skilled nursing visits for patch change were made on 7/9/13, four days later on 7/13/13, four days later on 7/17/13, and six days later on 7/23/13. The record failed to evidence every 72 hour Fentanyl patch change by skilled nursing services.</p> <p>3. On 7/29/13 at 1:16 PM, employee L indicated she and one other Registered Nurse (employee M) are responsible for all current patient's receiving skilled nursing services at the agency.</p> <p>4. Agency policy titled "Skilled Nursing Services" with an effective date of 1/1/13 states, "POLICY Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... B. Regularly reevaluates the client needs and coordinates the necessary services. ... d.</p>						

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	<p>Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the care plan and routine and complex skilled procedures. 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders. d. Wound care involving prescription medication and aseptic technique. e. Care of extensive pressure or stasis ulcers or other significant problems with skin integrity. ..."</p> <p>5. Agency policy titled "Services Provided" with an effective date of 1/1/13 states, "Agency will provide intermittent, part-time or extended hours of skilled nursing and home health aide services to clients in their places of residence. The intermittent or part-time services shall be provided on a visiting basis. ... If, for medical or safety reasons, a service to be provided must be completed at the scheduled time, and the Agency is unable, for any reason, to keep the scheduled appointment, arrangements will be made to complete the service through a contract with another provider or through other</p>						

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	reasonable means. Services shall be available seven (7) days a week, twenty-four (24) hours per day. Telephone answering service will be supplied twenty-four hours per day, seven days a week. On-call nurses will carry pagers/cell phones for contact in the event of an emergency."			

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure care followed a written plan of care established by a doctor of medicine in 3 of 4 records reviewed creating the potential to affect all the agency's patients. (#1, 2, and 3)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 that states, "SN [skilled nurse] visit frequency ... : 1 x [time] q [every] 3 days for wound txs [treatments] ... Assess Perform Instruct Pt/Cg [patient/caregiver] wound care as follows: xeroform et bactroban to open areas on L [left] heel et [and] coccyx, cover with tegaderm q [every] 3 days et [and] prn [as needed] until healed, Pt/Cg Wound care will be formed by: SN [skilled nurse]. HHA [home health aide] ...: 6 hrs [hours]/day x [times] 6 days/wk [week] x 1 week + 6 hrs [hours]/day x 7 days/wk[week] x 7 weeks + 6 hrs/day x 5 days/week x 1 week to assist w/personal care/ADLs</p>	N000522	<p>Failed to ensure care followed a written plan of care established by doctor of medicine. Failed to evidence wound care dressing changes had been preformed. All caregivers that provide skilled nursing will be in-serviced on the facilities policy Skilled Nursing Services by the DON or designee. The staff will be tested and demonstration of competency will be evaluated by DON or designee. Contacting other agencies to negotiate a contract for back up staff providers on an as needed basis, to assure continuous care. All potential missed visits will be reported to the DON immediately to ensure needs are met. DON or alternate director of nursing on call 24-7. DON will mandate skilled nurse to provide care/Tx or DON or alternate director of nursing will go.</p>	08/28/2013

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	<p>[activities of daily living]: grooming, dressing, ... Implement and Instruct Standard precautions/Infection control, ROM [Range of Motion]."</p> <p>A. The record failed to evidence wound care had been performed between the dates of 7/2 and 7/10/13.</p> <p>On 7/26/13 at 3:39 PM, employee B indicated there should have been a skilled nursing visit made July 5, 2013 but it was missed because staff availability.</p> <p>B. The record evidenced a physicians order dated 7/16/13 to increase skilled nursing visits to 1 time every other day for treatment to the left heel and coccyx area pressure sores.</p> <p>C. The record evidenced a physicians order dated 7/18/13 to increase skilled nursing to 1 time every other day for dressing changes to left heel and 2 times daily for 7 days a week for coccyx dressing changes until wound heals.</p> <p>1.) The record failed to evidence wound care/dressing changes had been performed on 7/18, 7/19, 7/20, 7/21, 7/22, 7/23, 7/24, 7/26, 7/27, or 7/28/13.</p> <p>2.) On 7/26/13 at 4:17 PM,</p>						

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	<p>employee B (director of nursing) indicated she was unaware of the physicians orders but did understand the need for increase of skilled nursing visits and agrees they were not made per physicians order.</p> <p>3.) Agency policy titled "Skilled Nursing Services" with an effective date of 1/1/13 states, "POLICY Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... B. Regularly reevaluates the client needs and coordinates the necessary services. ... d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the care plan and routine and complex skilled procedures. 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders. d. Wound care involving prescription</p>				

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	<p>medication and aseptic technique. e. Care of extensive pressure or stasis ulcers or other significant problems with skin integrity. ..."</p> <p>D. The Aide care plan dated 6/17/13 by employee F (registered nurse) states, "Frequency 6 hrs/day x 7 days/week." The document failed to include Range of Motion as a task to be performed by the aide.</p> <p>On 7/26/13 at 12:35 PM, employee B (director of nursing) indicated Range of Motion should have been included in the aide plan of care.</p> <p>E. The record failed to evidence home health aide visits were made on 6/23/13.</p> <p>2. Clinical record #2 included a plan of care established by the physician for the certification period 4/26/13 to 6/24/13 that states, "HHA visit frequency ... 4 hrs/day x 3 days/week x 1 week + 4 hrs/day x 7 days/wk x 8 weeks + 4 hrs/day x 1 day/wk x 1 week to assist w/personal care/ADLs/light housekeeping as needed ..." The record failed to evidence home health aide visits were made for week 2 (4/29/13 and 5/2/13), week 3 (5/8/13), week 4 (5/13/13), week 6 (5/28, 5/29, and 5/30/13), week 7 (6/6, 6/7, and 6/8/13),</p>						

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	<p>and week 8 (6/9/13).</p> <p>The agency policy with an effective date as 1/1/13 titled "Home Health Aide Services" states, "Policy Home Health Aide services will be provided to appropriate clients on an intermittent, part-time or full-time basis, under the direct supervision of an agency Registered Nurse/Therapist in accordance with a medically approved Plan of Care. ... SPECIAL INSTRUCTIONS ... 5. home health aides must document each visit at the time care is provided and submit documentation to the agency within seven (7) days."</p> <p>3. Clinical record #3 included a plan of care established by the physician for the certification period 5/26/13 to 7/24/13 that states, "SN [skilled nurse] visit frequency ... : 1 v [visit] x [times] 72 hrs [hours] x [times] 9 weeks for patch change ... <b>Medications</b> ... Fentanyl 50 mcg/patch transdermal every 72 hrs [hours] ... HHA frequency ... 6 hrs/day x 4 days/wk x 1 week + 6 hrs/day x 7 days/wk x 8 week ... HHA to assist w/personal care/ADLs: ... <b>60 day summary:</b> Pt is 81 y/o [gender] who lives alone with no available caregiver. Dx [diagnoses] of Renal Failure, COPD, Myalgia, HTN, Incontinence of B/B [bowel and bladder], and Anxiety. ... Pt is a high risk for</p>			

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	<p>hospitalization r/t [related to] inadequate pain management, needs help with ADLs and med management, lives alone, confusion, incontinence, and more than 2 secondary Dx. ... SN for fentanyl patch changes every three days ... "</p> <p>A. The record evidenced skilled nursing visits for patch change were made on 7/9/13, four days later on 7/13/13, four days later on 7/17/13, and six days later on 7/23/13. The record failed to evidence every 72 hour Fentanyl patch change by skilled nursing services.</p> <p>B. The record failed to evidence home health aide visits were made on 6/1, 6/8, 6/9, and 7/20/13 and failed to evidence documentation for the missed visits.</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record, agency policy review, and interview, the agency failed to ensure the registered nurse had provided treatments in accordance with the plan of care in 2 of 4 records reviewed creating the potential to affect all the agency's patients. (#1 and 3)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 that states, "SN [skilled nurse] visit frequency ... : 1 x [time] q [every] 3 days for wound txs [treatments] ... Assess Perform Instruct Pt/Cg [patient/caregiver] wound care as follows: xeroform et bactroban to open areas on L [left] heel et [and] coccyx, cover with tegaderm q [every] 3 days et [and] prn [as needed] until healed, Pt/Cg Wound care will be formed by: SN [skilled nurse]. HHA [home health aide] ...: 6 hrs [hours]/day x [times] 6 days/wk [week] x 1 week + 6 hrs [hours]/day x 7 days/wk[week] x 7 weeks + 6 hrs/day x 5 days/week x 1 week to assist w/personal care/ADLs</p>	N000537	<p>Failed to ensure the RN had provided treatments in accordance with the plan of care in 2 of 4 patient records . reviewed. Failed to evidence wound care had been performed between the dates of 7/2/13 and 7/10/13. Failed to evidence wound care dressing changes had been performed on 7/18, 7/18, 7/21, 7/22, 7/23, 7/24, 7/26, 7/27 and 7/28. Failed to evidence every 72 hours Fentanyl patch change by skilled nursing services. The DON or designee will inservice all personell responsible for providing skilled care on the Skilled Nursing Services policy annually. The inservice on Skilled Nursing Services will also be included in orientation provided to new hires by the DON or designee. Contacting other agencies to negotiate a contract to be a back up staff providers on an as needed basis, to assure continuous care. All potential missed visits will be reported to the DON immediately to ensure needs are met. DON or alternate director of nursing on call 24-7. DON will mandate skilled nurse to provide care/Tx or DON or alternate director of nursing will</p>	08/28/2013			

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	<p>[activities of daily living]: grooming, dressing, ... Implement and Instruct Standard precautions/Infection control, ROM [Range of Motion]."</p> <p>A. The record failed to evidence wound care had been performed between the dates of 7/2 and 7/10/13.</p> <p>On 7/26/13 at 3:39 PM, employee B indicated there should have been a skilled nursing visit made July 5, 2013 but it was missed because staff availability.</p> <p>B. The record evidenced a physicians order dated 7/16/13 to increase skilled nursing visits to 1 time every other day for treatment to the left heel and coccyx area pressure sores.</p> <p>C. The record evidenced a physicians order dated 7/18/13 to increase skilled nursing to 1 time every other day for dressing changes to left heel and 2 times daily for 7 days a week for coccyx dressing changes until wound heals.</p> <p>1.) The record failed to evidence wound care/dressing changes had been performed on 7/18, 7/19, 7/20, 7/21, 7/22, 7/23, 7/24, 7/26, 7/27, or 7/28/13.</p> <p>2.) On 7/26/13 at 4:17 PM,</p>		go.				

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	<p>employee B (director of nursing) indicated she was unaware of the physicians orders but did understand the need for increase of skilled nursing visits and agrees they were not made per physicians order.</p> <p>3.) Agency policy titled "Skilled Nursing Services" with an effective date of 1/1/13 states, "POLICY Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... B. Regularly reevaluates the client needs and coordinates the necessary services. ... d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the care plan and routine and complex skilled procedures. 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders. d. Wound care involving prescription</p>						

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	<p>medication and aseptic technique. e. Care of extensive pressure or stasis ulcers or other significant problems with skin integrity. ..."</p> <p>2. Clinical record #3 included a plan of care established by the physician for the certification period 5/26/13 to 7/24/13 that states, "SN [skilled nurse] visit frequency ... : 1 v [visit] x [times] 72 hrs [hours] x [times] 9 weeks for patch change ... <b>Medications</b> ... Fentanyl 50 mcg/patch transdermal every 72 hrs [hours] ... HHA frequency ... 6 hrs/day x 4 days/wk x 1 week + 6 hrs/day x 7 days/wk x 8 week ... HHA to assist w/personal care/ADLs: ... <b>60 day summary:</b> Pt is 81 y/o [gender] who lives alone with no available caregiver. Dx [diagnoses] of Renal Failure, COPD, Myalgia, HTN, Incontinence of B/B [bowel and bladder], and Anxiety. ... Pt is a high risk for hospitalization r/t [related to] inadequate pain management, needs help with ADLs and med management, lives alone, confusion, incontinence, and more than 2 secondary Dx. ... SN for fentanyl patch changes every three days ... ."</p> <p>The record evidenced skilled nursing visits for patch change were made on 7/9/13, four days later on 7/13/13, four days later on 7/17/13, and six days later on 7/23/13. The record failed to evidence</p>						

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	<p>every 72 hour Fentanyl patch change by skilled nursing services.</p> <p>3. On 7/26/13 at 4:17 PM, employee B indicated understanding of need for increase of skilled nursing visits and agrees they were not made per physicians order.</p> <p>4. Agency policy titled "Skilled Nursing Services" with an effective date of 1/1/13 states, "POLICY Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... B. Regularly reevaluates the client needs and coordinates the necessary services. ... d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the care plan and routine and complex skilled procedures. 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders. d.</p>			

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	Wound care involving prescription medication and aseptic technique. e. Care of extensive pressure or stasis ulcers or other significant problems with skin integrity. ..."			

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N000543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse provided the care ordered on the plan of care to prevent the deterioration of the wound status in 1 of 4 clinical records reviewed creating the potential to affect all the patients of the agency receiving skilled nursing services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1 had a start of care date of 6/14/13 and included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 that states, "SN [skilled nurse] visit frequency ... : 1 x [time] q [every] 3 days for wound txs [treatments] and Fentanyl patch change ... Assess Perform Instruct Pt [patient] / Cg [caregiver] wound care as follows: xeroform et [and] bactroban to open areas on L [left] heel et [and] coccyx, cover with tegaderm q [every] 3 days et [and] prn [as needed] until healed, Pt/Cg Wound care will be performed by: SN [skilled nurse]." The record also</p>	N000543	Failed to ensure the registered nurse provided the care ordered on the plan of care to prevent the deterioration of the wound status in 1 of 4 clinical charts reviewed. Failed to evidence wound care or Fentanyl patch change were performed as ordered by physician All staff providing skilled nursing care will be in-serviced on the following policies: 1)Assessment/Staging of Pressure Ulcers 2)Skilled Nurse Patient Missed Visit 3)Skilled Nursing ServicesContacting other agencies to negotiate a contract to be a back up staff providers on an as needed basis, to assure continuous care. All potential missed visits will be reported to the DON immediately to ensure needs are met. DON or alternate director of nursing on call 24-7. DON will mandate skilled nurse to provide care/Tx or DON or alternate director of nursing will go.DON or designee will audit all missed visits weekly to ensure MD was contacted and patients needs were met.	08/28/2013

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	<p>included a comprehensive assessment performed on 6/14/13 by employee F which states under "<i>INTEGUMENTARY STATUS ... TYPE</i> 1. Pressure Ulcer <i>LOCATION</i> L heel <i>SIZE</i> L 2" W 1" cm <i>WOUND BED</i> color: white tissue: Pale <i>SURROUNDING SKIN</i> Pink <i>TYPE</i> 2. Pressure Ulcer <i>LOCATION</i> Coccyx <i>SIZE</i> L 2" W 1" D 1 1/2" cm <i>WOUND BED</i> Color: Pink Tissue: Pale <i>SURROUNDING SKIN</i> Pink."</p> <p>A. The record contained a nursing visit record document dated 7/2/13 by employee C (Registered Nurse) evidencing wound care performed and Fentanyl patch change with skin assessment as follows; "<i>SKIN WOUND #1 LOCATION</i> heal of left foot L .5 W .5 <i>WOUND #2 LOCATION</i> top of coccyx L 1.5 W 1.5 Wound Tx performed this visit per POC [plan of care]."</p> <p>B. The record failed to evidence wound care or Fentanyl patch change was performed again until 7/10/13 at which time employee F (registered nurse) documented the following skin assessment, "<i>SKIN WOUND #1 LOCATION</i> L heel L 2.4 W 2.1 <i>DRAINAGE Amt</i> None <i>WOUND BED Color</i> Pink <i>Pain</i> Yes <i>WOUND #2 LOCATION</i> Coccyx Wound Tx</p>			

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	<p>[treatment] performed this visit per POC."</p> <p>On 7/26/13 at 3:39 PM, employee B indicated there should have been a skilled nursing visit made July 5, 2013, but it was missed because staff availability.</p> <p>C. The record contained a nursing visit record dated 7/16/13 by employee F evidencing wound care performed and Fentanyl patch change. The nursing visit record document included skin assessment as follows; "<b>SKIN WOUND #1 LOCATION</b> L heel <b>DRAINAGE Amt</b> None <b>WOUND #2 LOCATION</b> coccyx <b>DRAINAGE Amt</b> Min <b>Color</b> Blood/mu <b>Odor</b> Yes <b>WOUND BED Color</b> Black Wound Tx performed this visit per POC." The nursing visit record failed to evidence wound measurements but did evidence Foley catheter placement. On 7/26/13 at 4:17 PM, employee B(director of nursing) indicated measurements on all wounds need to be performed at least weekly.</p> <p>1.) Agency policy with an effective date of 1/1/13 titled "Assessment/Staging of Pressure Ulcers" states, "PRESSURE ULCER ASSESSMENT GUIDE In assessing the pressure ulcer, the following parameters should be addressed consistently. -Site,</p>						

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	<p>Stage of ulcer, and size of ulcer (include length, width, and depth) .... "</p> <p>2.) A document dated 7/16/13 titled "Case Conference and Coordination of Care Form" by employee F states, "<b><i>The above patient was discussed during:</i></b> Telephone contact Care coordination <b><i>COORDINATION OF CARE PARTICIPANTS INCLUDED:</i></b> M.D. S.N. <b><i>The following areas were discussed:</i></b> Wound Management <b><i>Catheter placement needed to heal pressure sore on coccyx area.</i></b> <b><i>PATIENT CONCERNS:</i></b> Pressure sore that are not healing. <b><i>DISCUSSION:</i></b> RN case manager spoke to [physician] about concerns that sore on coccyx area is getting worse d/t [due to] pt [patient] constantly being wet from urine leakage. RN asked for an order to catheterize pt for a mth[month] or two in attempt to keep pts skin dry and attempt to heal sore. [physician] agreed and gave verbal order. <b><i>Patient progress towards goals:</i></b> Pt agrees to the decision made by RN and MD. <b><i>Required Follow Up/Responsible Discipline:</i></b> RN to insert catheter and maintain the care needed."</p> <p>3.) The record evidenced a physicians order dated 7/16/13 to increase skilled nursing visits to 1 time every other day for treatment to the left heel and</p>						

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	<p>coccyx area pressure sores and a physicians order dated 7/17/13 for Foley catheter placement, both electronically signed by employee F.</p> <p>4.) The record evidenced a physicians order dated 7/18/13 by employee L (registered nurse) which states, "Increase sn [skilled nursing] to 1x [time] q [every] other day for dressing changes to left heel et [and] 2x [times] dly [daily] x [times] 7 days for coccyx dressing changes. Pending PA. Until wound heals."</p> <p>5.) On 7/29/13 at 11:16 AM, employee L indicated contacting the wound clinic and scheduling an appointment for the patient to be seen and also contacted the physician and acquiring the order dated 7/18/13 for the increase in skilled nursing visits for wound care. The employee indicates the updated information was then relayed to employee F through voicemail but doesn't remember if she documented it.</p> <p>D. The record failed to evidence a skilled nursing visit was made on 7/18/13.</p> <p>E. A document dated 7/19/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a skilled nursing missed visit due to "Clinician ill and no</p>			

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	<p>available substitute clinician <i>Patient's Needs were Met:</i> Authorized contact person/family/neighbors were contacted to check on patient."</p> <p>F. The record failed to evidence a skilled nursing visit was made on 7/20/13.</p> <p>G. The record failed to evidence a skilled nursing visit was made on 7/21/13.</p> <p>H. The record contained a nursing visit record document dated 7/22/13 by employee F evidencing Fentanyl patch change but no wound assessment or treatment was documented.</p> <p>I. The record failed to evidence a skilled nursing visit was made on 7/23/13.</p> <p>J. A document dated 7/24/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a skilled nursing missed visit due to "Clinician ill and no available substitute clinician <i>Patient's Needs were Met:</i> Authorized contact person/family/neighbors were contacted to check on patient."</p> <p>K. The record contained a nursing visit record document dated 7/25/13 by employee L evidencing wound care. The document included skin assessment as follows; "<u>SKIN WOUND #1</u></p>				

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	<p><b>LOCATION</b> L heel L 5 cm W 3 cm <b>WOUND BED</b> Color Red Pain None <b>WOUND #2 LOCATION</b> coccyx L 9 W 8 D .5 <b>DRAINAGE</b> Color Black Odor Yes <b>WOUND BED</b> Color Black Tissue Red Pain No. Wound Tx performed this visit per POC." The record failed to evidence Fentanyl patch change.</p> <p>1.) A document dated 7/25/13 titled "Care Coordination Note" by employee L which states, "<b>Coordination of care with:</b> Aide <b>Communicated via:</b> phone <b>Topic:</b> Coordinate care between disciplines <b>Discussion:</b> Pt was not home for skilled nursing visit to change dressing to coccyx. Pt.'s [family member] was notified and is aware that pt's treatment was not completed as [patient] was not home. Pt's family to change dressing as per order through Monday 7/29/13. <b>Resolution/Follow Up:</b> Sn to change dressing on Monday 7/29/13. <b>Clinical progress:</b> Ongoing/good."</p> <p>2.) On 7/26/13 at 4:32 PM, patient's family member indicated that on 7/25/13, the registered nurse (employee L) informed her of the physicians order to increase skilled nursing visits for dressing changes to wounds and informed the family member that a nurse would not be available to make the visits on 7/26, 7/27, and 7/28/13 and the family would need to</p>						

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	<p>provide wound care. The family member also indicated employee L had not changed the patient's Fentanyl patch on the 7/25/13 visit, the patch is sometimes placed by agency staff with no date of placement labeled, and the agency staff miss visits often, so family has to provide wound care and change the patient's Fentanyl patch.</p> <p>3.) On 7/29/13 at 11:16 AM, employee L indicated the patient's Fentanyl patch was not labeled with the date of application at one skilled nursing visit she made and does not remember the date of that visit but does agree the patch needs dated when applied.</p> <p>L. A document dated 7/26/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made with family to change fentanyl patch et [and] change dressing from 7/26/13 through 7/29/13."</p> <p>M. A document dated 7/27/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made with family to change fentanyl patch et [and] dressing</p>				

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	<p>changes."</p> <p>N. A document dated 7/28/13 titled "Skilled Nurse patient Missed Visit" by employee L indicated a missed visit by skilled nursing due to "Clinician Unavailable. <i>Patient's Needs were Met:</i> Other: arrangements made for family to change dressings et [and] fentanyl patch through Monday 7/29/13."</p> <p>O. On 7/29/13 at 10:29 AM, telephone interview with patient's power of attorney (POA) indicated the patient was hospitalized on 7/28/13 for weakness and a suspected infection. POA indicated patient's white blood cell count was increased, wounds had worsened, and patient did not receive the skilled nursing services ordered.</p> <p>2. Agency policy titled "Skilled Nursing Services" with an effective date of 1/1/13 states, "POLICY Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders) ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... B. Regularly reevaluates the client needs and coordinates the necessary services. ... d. Provides services requiring specialized</p>						

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	nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... 3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities. Management and evaluation of the care plan and routine and complex skilled procedures. 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders. d. Wound care involving prescription medication and aseptic technique. e. Care of extensive pressure or stasis ulcers or other significant problems with skin integrity. ..."			

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure written patient care instructions for the home health aide contained all the tasks ordered by the physician in 1 of 4 patient records reviewed creating the potential to affect all patients of the agency who receive home health aide services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care established by the physician for the certification period 6/14/13 to 8/12/13 that states, "HHA visit frequency ...: 6 hrs [hours]/day x [times] 6 days/wk [week] x 1 week + 6 hrs [hours]/day x 7 days/wk[week] x 7 weeks + 6 hrs/day x 5 days/week x 1 week to assist w/personal care/ADLs [activities of daily living]: grooming, dressing, ... Implement and Instruct Standard precautions/Infection control, ROM [Range of Motion]."</p> <p>The Aide care plan dated 6/17/13 by</p>	N000550	Failed to ensure written patient care instructions for the home health aide contained all tasks ordered by the physician in 1 of 4 patient charts reviewed. The document failed to include ROM as a task. The DON or designee will audit all patient care plans to ensure they address all of the patients needs with ADL's. . DON or designee will in-service all home health aides on the policy, Home Health Aide: Assignments. Case managers will audit all HHA work sheets to ensure they are addressing needs as ordered every week for the next 3 months or until compliance is obtained.DON or designee will audit 10% of all client charts quarterly to ensure they have been updated appropriately to address patients needs and match physicians orders	08/28/2013			

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	<p>employee F (registered nurse) states, "Frequency 6 hrs/day x 7 days/week." The document failed to include Range of Motion as a task to be performed by the aide.</p> <p>2. On 7/26/13 at 12:35 PM, employee B (director of nursing) indicated Range of Motion should have been included in the aide plan of care.</p> <p>3. Agency policy with an effective date as 1/1/13 titled "Home Health Aide: Assignment" states, "Policy The need for home health aide services is determined during the assessment by the nurse or therapist. when the services are ordered by the physician, the designated Registered Nurse/Therapist will assign and orient the aide to the care plan. ... Special instructions 1. The initial assessment for need of home health aide services shall be determined by the authorized nurse/therapist. The assignment of tasks will be identified in the home health aide care plan/Assignment sheet."</p>			

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N000606	<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 review and policy review, the agency failed to ensure the registered nurse made an on-site visit to the patient's home no less frequently than every 2 weeks as required by agency policy in 1 of 4 patient records reviewed of patients who had home health aide services creating the potential to affect all the agency's patients. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #3, start of care 6/11/10, included a plan of care with physician orders for skilled nursing services and home health aide services for certification period 5/26/13 to 7/24/13. The record failed to evidence supervisory visits were made by the registered nurse from 5/26/13 to 6/24/13.</li> <li>The agency policy titled "Home Health Aide Supervision" with an effective date as 1/1/13 states, "POLICY Agency shall provide Home Health Aide services under the direction and supervision of a</li> </ol>	N000606	Failed to ensure the registered nurse made an on-site visit to the patient's home no less frequently than every 2 weeks. DON or designee will in service all nursing staff on the policy for Skilled Nursing Services DON or designee will monitor and assign case managers schedules for mandatory requirement for supervisory visits at weekly nursing meeting for compliance.	08/28/2013			

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	Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. the frequency of supervision will be in response to Medicare regulations, agency policy and other state or federal requirements. ... SPECIAL INSTRUCTIONS ... 3. Supervisory visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client 's residence at least every two (2) weeks ... "			

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N000608	<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 review, policy and procedure review, and interview, the agency failed to ensure information in the clinical record was not falsified with the use of electronic signatures in 1 of 4 patient records reviewed creating the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. The agency policy with an effective date of 1/1/13 titled "Electronic Signature" states, "Policy an electronic signature will authenticate certain clinical record documents generated in the</p>	N000608	<p>Failure to ensure information in the clinical record was not falsified with the use of electronic signatures All employee computer log in 8/7/13 passwords changed. Authentication system requires employees to change passwords every 60 days with new, never used password with complexity requiring alphanumeric and case sensitive passwords and mandating that special characters be used. Passwords must be no less than Employees also have the ability to change their password more frequently should they desire but are mandated to do so at least every 60 days. IT department will audit</p>	08/07/2013			

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	<p>computerized medical record system. The documents affected by this policy include visit notes, charting sessions, verbal orders, and summaries. SPECIAL INSTRUCTIONS 1. For the purpose of the computerized home care record, the employee's use of the ID number and personal PIN will serve as their legal signature."</p> <p>2. Clinical record #4 contained a physician's order that states, "Caregiver: [employee B] (RN) Visit Date: 07/11/2013 ..... This form has been electronically signed by: [employee B] (RN) 07/12/2013 11:20:49 AM."</p> <p>A. On 7/29/13 at 11:40 AM, employee B indicated being on vacation from 6/28/13 until 7/16/13 and did not place any orders or document any orders during this time. The employee was not aware the order had been placed in her name.</p> <p>B. The agency policy with an effective date of 1/1/13 titled "Physician Orders" states, "SPECIAL INSTRUCTIONS 1. When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and</p>		100% of all employees responsible for skilled nursing and electronic charting for password change compliance every 60days. Administrator will ensure that IT departments performs audits.				

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	<p>interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature. ... 12. If client records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The agency will have a mechanism in place to prevent unauthorized access to records and a backup system in the event the automated system fails."</p> <p>3. On 7/29/13 at 3:31 PM, employee B indicated all case managers can see only their own patients but employee A (administrator) has access to all the patient records. Employee B indicated agency had no mechanism in place to prevent unauthorized access to records.</p>				

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N000614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on clinical record review and interview, the agency failed to ensure documents from a previous admission were not included with current admission documents in 1 of 4 patient records reviewed. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 6/14/13, contained a plan of care for certification period 6/14/13 to 8/13/13 and a physicians order to evaluate and treat for home healthcare services dated 6/15/13.</p> <p>The record evidenced a document titled "Medication Profile" with medication reconcile dates of 4/1/13 and</p>	N000614	<p>Failure to ensure documents from a previous admission were not included with current admission documents in 1 of 4 patient records reviewed. All nursing staff responsible for completing Admission/admission paperwork will be in-serviced on the policy regarding Admissions. DON or designee will audit every new admission within 2 weeks of admission to ensure all appropriate paperwork is completed, and that prior chart information remain separate from new admission chart. DON or designee will audit 10% of all patient charts every month until 100% completion of all charts are reviewed and in compliance.</p>	08/28/2013			

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	<p>4/12/13 electronically signed by employee F.</p> <p>2. On 7/26/13 at 2:40 PM, employee B indicated the patient had been a patient of the agency previously but discharged to a nursing home. Employee B indicated the medication profile should have been in the closed chart for this patient.</p>				