

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K108	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2016
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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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G 0000 Bldg. 00	<p>This was a federal home health complaint was investigation.</p> <p>Complaint # IN00203802- Unsubstantiated: Lack of Sufficient Evidence. Unrelated deficiencies are cited.</p> <p>Survey Dates: August 3, 4, 5, 8 and 9, 2016</p> <p>Medicaid Vendor #: 201184760</p> <p>Facility #: 004998</p> <p>Home Healthcare Associates INC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning August 9, 2016, for being found out of compliance with the Conditions of Participation 42 CFR 484.48: Clinical Records.</p>	G 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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G 0159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on document review and interview, the agency failed to ensure the plan of care was individualized to the functionality of the patient for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN</p>	G 0159	<p>Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition, needs, and services with the physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient ED Visits i. functional mobility j. review of patient assessment 2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation</p>	09/09/2016

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	<p>appropriately assigned the HHAs based on patient abilities, and failed to ensure the updates to the HHA care plans were revised.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ...</p>		<p>and interview of client/caregiver.)</p> <p>1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9. Demonstrates concern and a caring attitude toward client? Yes No 10. Treats client and caregiver with respect? Yes No 4. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 5. There will be a section where the RN Case Manager may document the observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 6. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and</p>	

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	<p>Patient is transferred from bed/chair with total lift assist."</p> <p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review</p>		<p>complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content. 7. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care." The Agency Administrator and Director of Nursing are responsible for compliance with this regulation.</p>	

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	<p>of the record for accuracy.</p> <p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The agency's un-dated policy tilted "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p>			

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	<p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current</p>			

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G 0173 Bldg. 00	<p>health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on document review and interview, the agency failed to ensure the nurses updated and revised the plan of care for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21</p>	G 0173	Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition, needs, and services with physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient ED Visits i. functional mobility j.	09/09/2016

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	<p>visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN updated and revised the plan of care since 2013 start of care date.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with</p>		<p>review of patient assessment2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation and interview of client/caregiver.)</p> <p>1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9. Demonstrates concern and a caring attitude toward client?Yes No 10. Treats client and caregiver with respect? Yes No 3. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 4. There will be a section where the RN Case Manager may document the</p>		

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	<p>total lift assist."</p> <p>D. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p>		<p>observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 5. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content.6. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care."The Director of Nursing will review RN Case Manager job description with all RN Case Managers. The 60 day summaries and Plan of Care will be audited by the Director of Nursing/designee. RN Case Managers failing to document complete accurate 60 day summaries and plans of care will receive re-education and counseling. On-going repeated mistakes will result in more counseling up to and including termination. The Agency Administrator and Director of Nursing are responsible for compliance with this regulation.</p>	

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	<p>E. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned</p>			

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	<p>patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p>			

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G 0176 Bldg. 00	<p>6. The agency's un-dated policy titled "Certified Home Health Aide Services/Supervision, "no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on document review and interview, the agency failed to ensure the nurses accurately documented patient assessment to coordinate services on the plan of care for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily</p>	G 0176	Home Healthcare Associates, Inc. will provide care that is ordered by the physician and coordinate changes in condition, needs, or services with physician. The RN Case Mangers will be re-instructed on what is to be included in the 60 day summary. The Director of Nursing will instruct the RN Case Managers on the utilization of the certification checklists. (The checklists identify all the tasks the RN case Manageris to complete at all certification time points.) In order to ensure compliance the agency will audit 100% of all certification documentation as follows: 1. The Director of Nursing or designee will utilize the certification checklist as an audit	09/09/2016

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	<p>to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN updated and revised the plan of care since 2013 start of care date.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p>		<p>tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that summaries contain all the required elements. 2. RNs with identified errors in documentation will be reeducated. Ongoing noncompliance will result in employee counseling up to and including termination. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to home health aide care plan, etc. The Director of Nursing is responsible for compliance with this regulation.</p>	

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	<p>D. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p>			

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	<p>E. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p>			

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	<p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>6. The agency's un-dated policy titled</p>			

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G 0224 Bldg. 00	<p>"Certified Home Health Aide Services/Supervision, "no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse."</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on document review and interview, the agency failed to ensure the Home Health Aide (HHA) plan of care was individualized to the functionality of the patient for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN</p>	G 0224	Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition, needs, and services with the physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient	09/09/2016

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	<p>1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN appropriately assigned the HHAs based on patient abilities, and failed to ensure the updates to the HHA care plans were revised.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced</p>		<p>ED Visits i. functional mobility j. review of patient assessment 2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation and interview of client/caregiver.)</p> <p>1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9. Demonstrates concern and a caring attitude toward client? Yes No 10. Treats client and caregiver with respect? Yes No 4. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 5. There will be a section where the RN Case</p>	

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	<p>the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p> <p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to</p>		<p>Manager may document the observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 6. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content. 7. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care." The Agency Administrator and Director of Nursing are responsible for compliance with this regulation.</p>	

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	<p>the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p> <p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate</p>			

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	<p>documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the</p>			

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G 0235 Bldg. 00	<p>registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "Certified Home Health Aide Services/Supervision, " no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse. "</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on document review and interview, the agency failed to ensure the accuracy of documented patient assessments and services provided for 2 of 11 clinical records reviewed(See G 236).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.</p>	G 0235	Home Healthcare Associates, Inc. will provide care that is ordered by the physician and coordinate changes in condition, needs, or services with physician. Home Healthcare Associates, INC will ensure the 60 day summary includes all the required elements. The RN Case Managers will be re-instructed on what is to be included in the 60 day summary. The Director of Nursing will instruct the RN Case Managers on the utilization of the certification checklists. (The checklists identify all the tasks the RN case Manageris to complete	09/09/2016

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G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge		at all certification time points.) The clinician will check off the tasks as they are completed and submit the checklist and completed certification documentation to the Director of Nursing or designee. In order to ensure compliance the agency will audit 100% of all certification documentation as follows: 1. The Director of Nursing or designee will utilize the certification checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that summaries contain all the required elements. 2. RNs with identified errors in documentation will be re-educated. Ongoing noncompliance will result in employee counseling up to and including termination. The Director of Nursing is responsible for compliance with this regulation.	

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	<p>summary. Based on document review and interview, the agency failed to ensure the accuracy of documented patient assessments and services provided for 2 of 11 clinical records reviewed. (# 1 and 7)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for Skilled Nurse (SN) 1 time a month for 3 months and 2 as needed (PRN) for change in condition and a recertification in last five days; Home Health Aide (HHA) 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN and HHA documented appropriately and accurately to the patient's abilities.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13." This</p>			G 0236	<p>Home Healthcare Associates, Inc. will provide care that is ordered by the physician and coordinate changes in condition, needs, or services with physician. Home Healthcare Associates, INC will ensure the 60 day summary includes all the required elements. The RN Case Managers will be re-instructed on what is to be included in the 60 day summary. The Director of Nursing will instruct the RN Case Managers on the utilization of the certification checklists. (The checklists identify all the tasks the RN case Manager is to complete at all certification time points.) The clinician will check off the tasks as they are completed and submit the checklist and completed certification documentation to the Director of Nursing or designee. In order to ensure compliance the agency will audit 100% of all certification documentation as follows: 1. The Director of Nursing or designee will utilize the certification checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that summaries contain all the required elements. 2. RNs with identified errors in documentation will be re-educated. Ongoing noncompliance will result in employee counseling up to and</p>		09/09/2016

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	<p>document failed to evidence the HHA Care Plan had been updated since start of care to reflect the patient could not walk, and failed to evidence the SN revised the plan of care.</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16. These visits failed to evidence the HHAs recognized the error of the assignment, and failed to evidence they paid attention to what they were charting.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p>		including termination. The Director of Nursing is responsible for compliance with this regulation.	

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	<p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p>			

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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815			
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	<p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The 2016 Fall log evidenced patient #7 had a fall on 3/17/16 related to a seizure, staff witnessed, no injuries, and MD was notified. A second fall occurred on 5/18/16 due to possible seizure, witnessed by staff, with injuries, group home staff refused SN visit.</p> <p>A. The current plan of care dated 7/19-9/16/16 contained Aide instructions for fall precautions, seizure precautions, assist with transfers, ambulation, exercise program and DME of shower chair, grab bars, transfer belt and wheelchair.</p>						

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	<p>B. The un-titled document dated 3/18/17 stated "During recertification seizure activity resulting in a fall was reported to [employee O] who reported it to the DON [director of nursing]. Group home staff reported seizure, no injury noted and MD is aware that patient has increased seizure activity and of fall. Most recent fall reported as being yesterday." This document contained the wrong year, no time, and was not signed by the creator.</p> <p>C. The un-titled document dated 5/8/17 stated "Call received from [employee C, office manager] that patient had "seizure like activity" and a fall. Call placed to DSP [Direct Service Provider], [DSP name]. [DSP name] reported that the patient had a seizure while in the shower with the HHA resulting in a fall. [DSP name] denied the need for a SN visit to follow up. Stated the doctor was aware of frequent seizures. Denies serious injury but does report scratch above left eye and redness to right knee but no broken skin. Refused follow up visit from SN." This document contained the wrong year, no time, and was not signed by the creator.</p> <p>D. During interview on 8/5/16 at 2:30 PM, employee A stated the 2017 dates were an error.</p>			

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	<p>3. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>4. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>5. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled</p>			

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N 0000 Bldg. 00	<p>service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>6. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>This was a state home health complaint</p>	N 0000		

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N 0524 Bldg. 00	<p>was investigation.</p> <p>Complaint # IN00203802- Unsubstantiated: Lack of Sufficient Evidence. Unrelated deficiencies are cited.</p> <p>Survey Dates: August 3, 4, 5, 8 and 9, 2016</p> <p>Medicaid Vendor #: 201184760</p> <p>Facility #: 004998</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status.</p>			

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	<p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on document review and interview, the agency failed to ensure the plan of care was individualized to the functionality of the patient for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN</p>	N 0524	Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition, needs, and services with the physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient ED Visits i. functional mobility j. review of patient assessment 2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation	09/09/2016

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	<p>appropriately assigned the HHAs based on patient abilities, and failed to ensure the updates to the HHA care plans were revised.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ...</p>		<p>and interview of client/caregiver.)</p> <p>1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9. Demonstrates concern and a caring attitude toward client? Yes No 10. Treats client and caregiver with respect? Yes No 4. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 5. There will be a section where the RN Case Manager may document the observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 6. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and</p>	

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	<p>Patient is transferred from bed/chair with total lift assist."</p> <p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review</p>		<p>complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content. 7. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care." The Agency Administrator and Director of Nursing are responsible for compliance with this regulation.</p>	

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	<p>of the record for accuracy.</p> <p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The agency's un-dated policy tilted "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p>			

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	<p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current</p>			

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N 0542 Bldg. 00	<p>health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on document review and interview, the agency failed to ensure the nurses updated and revised the plan of care for 1 of 11 clinical records reviewed. (# 1) Findings include 1. Clinical record # 1 was reviewed on</p>	N 0542	Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition, needs, and services with physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing	09/09/2016

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	<p>8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN updated and revised the plan of care since 2013 start of care date.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p>		<p>concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient ED Visits i. functional mobility j. review of patient assessment 2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation and interview of client/caregiver.)</p> <ol style="list-style-type: none"> 1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9. Demonstrates concern and a caring attitude toward client? Yes No 10. Treats client and caregiver with respect? Yes No 3. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between 	

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	<p>C. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p> <p>D. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on</p>		<p>the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 4. There will be a section where the RN Case Manager may document the observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 5. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content. 6. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care." The Director of Nursing will review RN Case Manager job description with all RN Case Managers. The 60 day summaries and Plan of Care will be audited by the Director of Nursing/designee. RN Case Managers failing to document complete accurate 60 day summaries and plans of care will receive re-education and counseling. On-going repeated mistakes will result in more counseling up to and including termination. The Agency Administrator and Director of Nursing are responsible for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K108	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2016
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NAME OF PROVIDER OR SUPPLIER HOME HEALTHCARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6431 GEORGETOWN NORTH BLVD FORT WAYNE, IN 46815
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	<p>2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p> <p>E. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation</p>		compliance with this regulation.	

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	<p>of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The</p>			

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N 0544 Bldg. 00	<p>comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>6. The agency's un-dated policy titled "Certified Home Health Aide Services/Supervision, "no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse."</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on document review and interview, the agency failed to ensure the nurses accurately documented patient assessment to coordinate services on the plan of care for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p>	N 0544	Home Healthcare Associates, INC will ensure the 60 day summary includes all the required elements. The RN Case Managers will be re-instructed on what is to be included in the 60 day summary. The Director of Nursing will instruct the RN Case Managers on the utilization of the certification checklists. (The checklists identify all the tasks the	09/09/2016

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	<p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN updated and revised the plan of care since 2013 start of care date.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p>		<p>RN case Manageris to complete at all certification time points.) The clinician will check off the tasks as they are completed and submit the checklist and completed certification documentation to the Director of Nursing or designee. In order to ensure compliance the agency will audit 100% of all certification documentation as follows: 1. The Director of Nursing or designee will utilize the certification checklist as a audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that summaries contain all the required elements. 2. RNs with identified errors in documentation will be re-educated. Ongoing noncompliance will result in employee counseling up to and including termination. The Director of Nursing is responsible for compliance with this regulation.</p>	

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	<p>C. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p> <p>D. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse;</p>			

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	<p>employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p> <p>E. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides</p>			

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	<p>assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of</p>			

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N 0550 Bldg. 00	<p>desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p> <p>6. The agency's un-dated policy titled "Certified Home Health Aide Services/Supervision, "no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse."</p> <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. Based on document review and interview, the agency failed to ensure the Home Health Aide (HHA) plan of care was individualized to the functionality of</p>	N 0550	Home Healthcare Associates, Inc. staff will provide care that is ordered by the physician and coordinate changes in condition,	09/09/2016

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	<p>the patient for 1 of 11 clinical records reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for SN 1 time a month for 3 months and 2 PRN for change in condition and a recertification in last five days; HHA 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence the SN appropriately assigned the HHAs based on patient abilities, and failed to ensure the updates to the HHA care plans were revised.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2) (In Progress) Start Date 12/19/13."</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast</p>		<p>needs, and services with the physician. 1. The Administrator and Director of Nursing is implementing a new daily reporting mechanism in which the RN Case Managers must report the following: a. Home health aide staffing concerns b. RN staffing concerns c. Patient "changes in condition" d. Patients newly started on antibiotics e. Patient falls f. Patient Concerns/Needs g. Patient Hospitalizations h. Patient ED Visits i. functional mobility j. review of patient assessment 2. The RN Case Managers will be instructed on a new Home Health Aide Supervisory Visit Tool and Process that will include the following: The Home Health Aide performs the following: (Answer questions based on observation and interview of client/caregiver.) 1. Implements the Home Health Aide Plan of Care? Yes No 2. Implements and maintains Standard Precautions per Agency policy? Yes No 3.. Arrives on time, stays the required length of time and is reliable? Yes No 4. Performs assigned tasks per standard care protocol? Yes No 5. Performs tasks as requested by client and/or caregiver within his/her job description? Yes No 6. Relates well with the client and family? Yes No 7. Follows the Agency dress code? Yes No 8. Immediately reports all concerns, client issues and/or problems to the RN Case Manager and/or Supervisor? Yes No 9.</p>				

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	<p>... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p> <p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p>				<p>Demonstrates concern and a caring attitude toward client? Yes No 10. Treats client and caregiver with respect? Yes No 4. In addition, there will be a Section titled Coordination of Care which will facilitate discussion between the patient, aide, and nurse to evaluate if the patient needs are being met, if there are changes needed to the home health aide care plan etc. 5. There will be a section where the RN Case Manager may document the observation of the home health aide performing assistance with transfers, ambulation, use of assistive devices etc. 6. The Director of Nursing or designee will utilize the checklist as an audit tool to ensure the assessments are accurate and complete, the Plan of Care or physician orders reflect the needs identified on the comprehensive assessment and that the summaries contain all required content. 7. The Plan of Care policy was updated to include: "Director of Nursing or designee may develop the Plan of Care for the purpose of care oversight and coordination of care." The Agency Administrator and Director of Nursing are responsible for compliance with this regulation.</p>		

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	<p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p> <p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this</p>			

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	<p>patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>3. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned patient."</p> <p>4. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of</p>			

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N 0608 Bldg. 00	<p>delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>5. The agency's un-dated policy titled "Certified Home Health Aide Services/Supervision, " no number, stated "POLICY: ... POC: ... A Plan of Care specifically written for that patient will be provided to the HHA by a registered nurse. "</p> <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: (1) The medical plan of care and</p>			

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	<p>appropriate identifying information.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(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.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on document review and interview, the agency failed to ensure the accuracy of documented patient assessments and services provided for 2 of 11 clinical records reviewed. (# 1 and 7)</p> <p>Findings include</p> <p>1. Clinical record # 1 was reviewed on 8/8/16. Start of care date 12/18/13, discharge date 2/12/16. The plan of care dated 2/7-4/6/16 contained orders for Skilled Nurse (SN) 1 time a month for 3 months and 2 as needed (PRN) for change in condition and a recertification in last five days; Home Health Aide (HHA) 21 visits a week for 8 weeks, 2-3 visits daily to total 4-6 hours per patient request. HHA instructions included Activity: Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]). The record failed to evidence</p>	N 0608	Home Healthcare Associates, INC will ensure the 60 day summary includes all the required elements. The RN Case Managers will be re-instructed on what is to be included in the 60 day summary. The Director of Nursing will instruct the RN Case Managers on the utilization of the certification checklists. (The checklists identify all the tasks the RN case Manageris to complete at all certification time points.) The clinician will check off the tasks as they are completed and submit the checklist and completed certification documentation to the Director of Nursing or designee. In order to ensure compliance the agency will audit 100% of all certification documentation as follows: 1. The Director of Nursing or designee will utilize the certification checklist as an audit tool to ensure the assessments are accurate and complete, the Plan ofCare or physician orders reflect the needs	09/09/2016

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	<p>the SN and HHA documented appropriately and accurately to the patient's abilities.</p> <p>A. The Multidisciplinary Care Plan dated as printed on 8/8/2016 stated "Interventions ... 5. Activity- Ambulate patient using assistive device (cane, crutches, walker, O2 [oxygen]) (In Progress) Start Date 12/19/13." This document failed to evidence the HHA Care Plan had been updated since start of care to reflect the patient could not walk, and failed to evidence the SN revised the plan of care.</p> <p>B. The SN Visit Note dated 2/5/16, created by employee J, stated "Review of Systems ... Musculoskeletal ... Gait Non-ambulatory- Is chairfast or bedfast ... DME/Assistive Devices ... Wheelchair/exercise equipment ... NARRATIVE NOTES ... Patient is wheelchair bound and completely dependant in transfers, bathing, dressing, meal prep ... Patient is transferred from bed/chair with total lift assist."</p> <p>C. The Aide Visit Notes evidenced the HHAs charted that they ambulated the patient on 2/11, 2/12, 2/10, 2/9, 2/8, and 2/7/16. These visits failed to evidence the HHAs recognized the error of the assignment, and failed to evidence</p>		<p>identified on the comprehensive assessment and that summaries contain all the required elements.</p> <p>2. RNs with identified errors in documentation will be re-educated. Ongoing noncompliance will result in employee counseling up to and including termination. The Director of Nursing is responsible for compliance with this regulation.</p>	

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	<p>they paid attention to what they were charting.</p> <p>D. The Plan of Care Summary dated 2/11/16 by employee B stated "Summary of Care Rendered in Past Certification Period ... Patient is wheelchair bound and completely dependant in transfers ... Patient is transferred from bed/chair with total lift assist."</p> <p>E. During interview on 8/8/16 at 12:20 PM, employee A stated the previous director of nursing (employee EE) created the Aide Care Plan in 2013 at start of care, and the last update to the Aide care plan was on 2/1/16 by employee O. Employee A stated that employee O last saw the patient on 1/15/16. Employee A stated if the nurses have too many patients to see then they call her and tell her if anything is new with the patients and to please update the aide care plans.</p> <p>-This interview evidenced that although the patient had been on service since 2013, the agency did not recognize the issue for over 2 years; employee O had not assessed the patient since January 15, 2016 and still had not recognized the issue and still reviewed the HHA care plan on 2/1/16 which was 6 days prior to the next certification period and 4 days</p>			

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	<p>prior to the recertification assessment which was completed by another nurse; employee J assessed the patient last on 2/5/16 and did document the patient could not walk/ambulate; and still a third nurse (employee A) will update HHA care plans not based on her own assessment of the patient and/or review of the record for accuracy.</p> <p>F. During telephone interview on 8/8/16 at 9:09 AM, patient # 1 stated they cannot walk, and only have use of part of their left arm; have no movement in the legs, no movement from the shoulders down. Patient # 1 stated Home Healthcare Associates never attempted to make them walk because they cannot stand or walk.</p> <p>G. During interview on 8/9/16 at 12:20 PM, employee H stated she did not ambulate patient #1; she would always put the patient in the wheelchair as this patient could not walk. Employee H stated she would circle wheel chair, not ambulate and it if she circled ambulate then that was a mistake.</p> <p>2. The 2016 Fall log evidenced patient #7 had a fall on 3/17/16 related to a seizure, staff witnessed, no injuries, and MD was notified. A second fall occurred on 5/18/16 due to possible seizure,</p>			

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	<p>witnessed by staff, with injuries, group home staff refused SN visit.</p> <p>A. The current plan of care dated 7/19-9/16/16 contained Aide instructions for fall precautions, seizure precautions, assist with transfers, ambulation, exercise program and DME of shower chair, grab bars, transfer belt and wheelchair.</p> <p>B. The un-titled document dated 3/18/17 stated "During recertification seizure activity resulting in a fall was reported to [employee O] who reported it to the DON [director of nursing]. Group home staff reported seizure, no injury noted and MD is aware that patient has increased seizure activity and of fall. Most recent fall reported as being yesterday." This document contained the wrong year, no time, and was not signed by the creator.</p> <p>C. The un-titled document dated 5/8/17 stated "Call received from [employee C, office manager] that patient had "seizure like activity" and a fall. Call placed to DSP [Direct Service Provider], [DSP name]. [DSP name] reported that the patient had a seizure while in the shower with the HHA resulting in a fall. [DSP name] denied the need for a SN visit to follow up. Stated the doctor was aware of frequent seizures. Denies</p>			

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	<p>serious injury but does report scratch above left eye and redness to right knee but no broken skin. Refused follow up visit from SN." This document contained the wrong year, no time, and was not signed by the creator.</p> <p>D. During interview on 8/5/16 at 2:30 PM, employee A stated the 2017 dates were an error.</p> <p>3. The agency's un-dated policy titled "Documentation Standards and Guidelines," no number, stated "Procedure: ... 1. Correct: Accurate documentation of observations, assessments, events, services, treatments, accurate notation of the date and time of documentation; signature of the documenter. ... 8. Consistent: Accurate reflection of the client condition over time and among different caregiving professionals."</p> <p>4. The agency's un-dated job description titled "Registered Nurse," no number, stated "Essential Job Functions Provides assessment, management, and evaluation of the patient's plan of care ... Monitors treatments rendered by other providers such as ... home health aide ... Coordinates the use of durable medical equipment ... Completes documentation at each needed interval for each assigned</p>			

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	<p>patient."</p> <p>5. The agency's un-dated policy titled "Plan of Care," no number, stated "A nursing Plan of Care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. The Nursing Plan of Care must contain the following: A plan of care and appropriate patient identifying information ... Medications, diet, and activities ... The signature of the registered nurse who developed the plan."</p> <p>6. The agency's un-dated policy titled "OASIS Reporting and Comprehensive Assessment," no number, stated "Comprehensive Assessment: ... Each patient will receive a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. ... The comprehensive assessment will identify the patient's continuing need for home care and meet the patient's medical, nursing, rehab, social, and discharge planning needs."</p>			

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