

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157624		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER PHYSIOCARE HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 S EARL AVE STE 1A LAFAYETTE, IN 47905			
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N0000	<p>This visit was a state home health relicensure survey.</p> <p>Survey Dates: January 23, 24, and 25, 2012.</p> <p>Facility # 012233</p> <p>Medicaid #: 200973060</p> <p>Surveyor: Bridget Boston RN, PHNS, Team Leader Marty Coons, RN, PHNS, Team Member</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 31, 2013</p>			N0000	<p>ok I could not get this to work till today., so I fed ex a copy and I answered a response to each thing she wrote. SO placing into this tag box will be redundant but if you look at poc it goes directly with each item./ THanks Kelley</p>		

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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N0456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on document review, policy review, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency reviewed with the potential to affect all current patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Administrative documents failed to evidence the agency conducted an ongoing quality improvement program. The untitled documents provided for review were non specific regarding activities and lacked objective data, specific and measurable agency goals, and agency planning. The policy, revised April 2011, titled 	N0456	<p>This Deficiency will be corrected by the following: we had the data however were not objectively measuring into statistical data. Now we will be outputting the data into our binder for QUAPI so surveyors can see what we are measuring. Currently we will continue measuring the HCA and unrepresent HCA 2/15/13 visit and when they are complete now we will also take this data and objectively measure percentage correct based on employees. Each employee then will be given a requirement to increase their percentage by 10 percent improvement each quarter of their missing HCA visits recorded on time until 100% is reached. This will be the responsibility of the DON and the ADON at our agency. We will have our next meeting to get our data into objective measurements on 2/15/2013. The week of 2/11-2/15 we will</p>	02/15/2013	

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	<p>"Responsibilities in Improving Performance" states, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. Senior management will have the responsibility will have the responsibility to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service. Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications."</p> <p>3. On 1/25/13 at 6 PM, employee A indicated there was no further information available.</p>		<p>be compiling the data for analysis at the meeting. This was the Portion missing from our QUAPI and will then meet the requirement. We will continue doing our daily audits, but now we will also take that data and place into percentages for each clinician based on correct and ontime. To prevent this from Happening in future this new system will be a requirement and taught to all auditors that auditing is not complete until the percentages are also analyzed and corrective action taken on those clinicians.</p>		

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

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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure all direct care staff files included a 2 - step tuberculosis screening or chest x-ray at hire or a negative tuberculosis screening history for the previous 12 months for 4 of 9 direct care staff with the potential to affect all of the agency's patients and staff. (employees C, D, E, and H)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel record C, a registered nurse, date of hire 9/21/11 and first patient contact 9/26/11, failed to evidence a negative tuberculosis screening within the 12 months prior to hire or that a tuberculosis two step skin test was administered at hire. Personnel record D, a home health aide, date of hire 7/13/11 and first patient contact 7/16/11, failed to evidence two or 	N0464	<p>This deficiency is being corrected as follows. Our policy was written correctly but not being followed correctly. As of 2/7/2013 all charts were re audited for proper TB documentation. All charts out of compliance we requested by those clinicians in writing the past negative tb tests that were within a year. Once we receive these tb tests all of our charts will then be 100% correct, as everyone received a tb at hire. To Human Resources director will now have to have approval proving with a checklist that the tb was completed per State regulations with a two step or prior negatives within the appropriate time frame before the first visit can take place. This rule began 2/7/2013. The responsible person for this correction will be the Human Resource Director for the checking of every file, and the Administrator or DON for signing off the checklist before allowing them to enter the field. All outstanding documents have now been requested and we expect to</p>	03/01/2013	

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	<p>more negative tuberculosis screening within the previous 12 months prior to hire, a tuberculosis screening at hire, or the results of a chest X-ray.</p> <p>3. Personnel record E, a home health aide, date of hire 11/23/12 and first patient contact 11/27/12, failed to evidence a negative tuberculosis screening within the previous 12 months prior to hire, that a two step PPD had been administered at hire, or the results of a chest X-ray.</p> <p>4. Personnel record H, a registered nurse, date of hire 8/27/12 and first patient contact 9/5/12, failed to evidence a negative tuberculosis screening within the previous 12 months prior to hire, that a two step PPD had been administered at hire, or the results of a chest X-ray.</p> <p>5. The policy titled "Human, Financial, and Physical Resources" number C:3-003.5 states, "Personnel must have Mantoux test or show evidence there is no active tuberculosis in the past 12 months (by providing a copy of a Mantoux / TB test taken within the past 12 months) prior to providing care. ... Documentation of thee tests will be maintained in the personnel health file."</p>		<p>have all files 100% in compliance by March 1, 2013.</p> <p>3/1/2013 This registered nurse had prior employment with the testing completed within the 12 months prior to hire. This will then fix her chart. Human Resource Director requested this with employees request in writing to her prior employer on 2/7/2013. HR director is responsible for making further attempts if documentation is not received. HR director will make sure her chart is complete at latest on 3/1/2013.</p> <p>3/1/20/13This home health aide had prior employment with the testing completed within the 12 months prior to hire. This will then fix her chart. Human Resource Director requested this with employees request in writing to her prior employer on 2/7/2013. HR director is responsible for making further attempts if documentation is not received. HR director will make sure her chart is complete at latest on 3/1/2013.</p> <p>3/1/20/13This home health aide had prior employment with the testing completed within the 12 months prior to hire. This will then fix her chart. Human Resource Director requested this with employees request in writing to her prior employer</p>		

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	6. On 1/24/13 at 3:45 PM, employee I indicated she was not aware of the time requirement for a 2 step tuberculosis screening and there was not any further information available.		on 1/30/2013 during survey. HR director did receive this documentation and this chart is now complete. HR director Double checked her chart and her chart is now in compliance on 2/8/2013. 2/8/2013 This registered nurse had prior employment with the testing completed within the 12 months prior to hire. This will then fix her chart once obtained. Human Resource Director requested this with employees request in writing to her prior employer on 2/7/2013. HR director is responsible for making further attempts if documentation is not received. HR director will make sure her chart is complete at latest on 3/1/2013. 3/1/20/13		

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N0472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on document review, policy review, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency reviewed with the potential to affect all current patients.</p> <p>Findings include:</p> <p>1. Administrative documents failed to evidence the agency conducted an ongoing quality improvement program. The untitled documents provided for review were non specific regarding</p>	N0472	<p>To correct this deficiency we are meeting on week of 2/12/13 to continue our current plan. As an agency our largest area that needs to be improved is HCA present and HCA un present visits. We will have present our QUAPI members and also our auditors. We have created a tracking sheet to determine the percentage correct of HCA sup visits by clinician. At this meeting on February 12 we will be teaching the auditors how to use this sheet and then turning the sheet in every friday to the DON to add to our objective data. We will be measuring this data monthly on our clinicians. We will be requiring a 10% improvement in this area until 100% accuracy is met by all staff. The individuals responsible for this will be the auditors and direct</p>	02/16/2013	

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	<p>activities and lacked objective data, specific and measurable agency goals, and agency planning.</p> <p>2. The policy, revised April 2011, titled "Responsibilities in Improving Performance" states, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. Senior management will have the responsibility will have the responsibility to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service. Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications."</p> <p>3. On 1/25/13 at 6 PM, employee A indicated there was no further information available.</p>		<p>oversight by the DON. To prevent this issue from re occurring in the future. Every quarter there will be a week worth of an hour preparation daily to get the objective data gathered together.</p>		

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N0504	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient was advised in advance of care of the frequency of services to be provided for 9 (#s 1-9) of 9 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care (SOC) 10/28/12, failed to evidence the patient had been advised in advance of the proposed frequency of visits to be furnished. 2. Clinical record 2, SOC 10/20/12, failed to evidence the patient had been advised in advance of the proposed frequency of visits to be furnished. 3. Clinical record 3, SOC 7/31/12, failed to evidence the patient had been advised 	N0504	<p>Inservice scheduled for week of 2/11/2013. Inservice to consist of appropriate completion of admission form, which is to include frequency and type of services to be provided for patient so patient is aware at time of admission. Each new admission paperwork to be analyzed once returned to agency office. DON/ADON/administrator to verify patient has been advised in advance via admission paperwork the type of services and frequency to be provided. Expectation is to see 20% improvement weekly until 100% achieved by 3/20/2013. For clinical record 1,2,3,4,5,6,7,8,9, This record we did a new admission form on 2/7/2013. The clinician at this time filled the visit frequency orders in</p>	03/20/2013

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	<p>in advance of the proposed frequency of visits to be furnished.</p> <p>4. Clinical record 4, SOC date 12/10/12, included a consent for services and a comprehensive assessment dated 12/10/12 and completed by employee N. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p> <p>5. Clinical record 5, SOC 1/5/13, included a consent for services and a comprehensive assessment completed by employee B and dated 1/5/13. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p> <p>6. Clinical record 6, SOC 1/18/13, included a consent for services and a comprehensive assessment completed by employee J and dated 1/18/13. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p> <p>7. Clinical record 7, SOC 1/8/13, included a consent for services and a comprehensive assessment completed by employee H and dated 1/8/13. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p>		<p>as written per plan of care and needed per patient. At this time Patient signature for this was also obtained. The case manager was directly responsible for fixing and informing the VFO to the client and obtaining signature of completion. This was then reviewed by the DON to verify completion. To Prevent this from further incidences occuring all case managers, and clinicians will be in inservice on the week of 2/11/13Item 10 - This will be corrected with an inservice explaining proper use of admission form with vfo noted and discussed with patient. To prevent this from happening in future we will be auditing paper charts as well for these forms expecting 100% accurate within one month.</p> <p>3/15/2012 The DON and ADON will in charge of implementing the inservice as well as the audits of new charts. This will be inserviced week of 2/11/2013 with 100% compliance by 3/15/2013This policy will be taken out and re educated in the in service the week of 2/11/2013. The DON will be responsible for educating and testing of the policy so that it is adhered to. There will be auditing of the admission form beginning 2/11/13 and by 3/15/2013 we expect to</p>		

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	<p>8. Clinical record 8, SOC 1/21/13, included a consent for services and a comprehensive assessment completed by employee N and dated 1/21/13. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p> <p>9. Clinical record 9, SOC date 1/17/13, included a consent for services and a comprehensive assessment completed by employee H and dated 1/17/13. The record failed to evidence the patient was advised in advance of care the proposed frequency of visits.</p> <p>10. On 1/23/13 at 4 PM, employee C indicated they did not think they needed to propose a frequency of visits any longer and that they had stopped providing the information at the start of care.</p> <p>11. The policy titled "Uniform Quality Of Care and Quality Assessment" revised date April 2011 stated, "Admission and discharge criteria will be adhered to according to Federal and State guidelines for licensure and certification."</p>		<p>have 100% compliance with educating and documenting to patients of the vfo. 3/15/2013</p>		

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the attending physician was consulted regarding the admission to home health care and orders were obtained and documented for the skilled care to be provided prior to the provision of skilled care for 7 of 9 clinical records reviewed (# 1, 3, 5, 6, 7, 8, and 9) with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 1 start of care (SOC) 10/28/12, evidenced employee L, a registered nurse, completed the comprehensive assessment on 10/28/12 and provided wound care during the visit. The record failed to evidence the registered nurse, or any one else from the agency, consulted with the attending physician and obtained an order(s) for admission of the individual for skilled home health care and an order for wound care prior to the provision of care. The record evidenced a physician order to</p>	N0522	<p>Inservice to be conducted week of 2/11/2013 inservice to include education regarding comprehensive assesment to be completed prior to SOC in order to evaluate patient's home care needs. Upon completion of comprehensive assessment, agency will notify physician of findings and request verbal orders for SOC. Clinicians will chart on paper the new orders for admission for all disciplines afer the evalaution. Upon each disciplines completion of evaluation, agency will obtain orders for plan of care, frequency of visits. Referral's will be audited weekly to assure compliance with the above. DON and ADON will be in charge of inservicing the staff on week of 2/11/2013 and continuing audits to meet the expectations for this agency. Expectation is to see 20% improvement weekly until 100% achieved by 3/15/2013. To prevent this from occurring in future ongoing audits will be completed monthly. With requirement of 95 percent and above for full audit not to occur. In this case clinical record number 1,2,3,4,5,6, 8,9 our staff</p>	02/16/2013	

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	<p>provide services was received on 11/6/12 by employee C after the patient had received physical therapy, skilled nursing services, and home health aide services from 10/28/12 through 11/6/12.</p> <p>On 1/24/13 at 11:19 AM, employee C indicated the clinical record did not evidence the attending physician was consulted for admission to home care and orders were obtained for the services to be provided prior to the agency rendering any skilled services.</p> <p>2. Clinical record # 5, SOC 1/5/13, evidenced employee B, a registered nurse, completed the comprehensive assessment on 1/5/13 and provided care to a wound which measured 11.9 centimeters X 8.4 centimeters X 0.1 centimeters in depth during the visit. The record failed to evidence registered nurse, or any one else from the agency, consulted with the attending physician and obtained an order(s) for admission of the individual for skilled home health care and an order for wound care prior to the provision of care. The record evidenced a physician order to provide services was received on 1/6/13 after the patient had received skilled nursing services with wound care on 1/5/13 and 1/6/13.</p> <p>On 1/25/13 at 4:30 PM, employee B</p>		<p>will be in serviced about calling physicians after the initial assessment and creating the appropriate plan of care and receiving verbal orders from MD. They will then take an exam on this protocol to prevent this error from occurring in future. These cases listed above then will then be corrected post the inservice the week of 2/11/2013 by the case manager informing the physician of the plan of care and getting verbal approval. This communication will be done on a new paper form titled " After assessment POC orders" until we figure out the issue in our software not documenting that this was done.</p> <p>2/15/2013 Then the DON will be responsible to meet with the auditors beginning friday 2/15/2013 to check each admission that the verbal orders were received to initiate all care for every patient We will be expecting 100 % compliance with this procedure beginning first week of 2/15/2013. To prevent future occurences, We will then require 4 weeks consecutively at 100 Percent correctness before this goes back into the random chart audits. If it falls below 90 percent with the random chart audits for orders after initial assessments then we will resume all chart audits until 4 consecutive weeks occur at 100%. The DON will be responsible for direct oversight of the above.</p>		

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	<p>indicated the clinical record did not evidence the attending physician was consulted for admission to home care and orders were obtained for the services to be provided prior to the agency rendering any skilled services.</p> <p>3. Clinical record # 6, start of care 1/18/13, evidenced employee J, a physical therapist, completed the comprehensive assessment on 1/18/13 and provided physical therapy services during the visit. The record failed to evidence the physical therapist, <u>or any one else from the agency, consulted with the attending physician and obtained physician order(s) to admit the patient to home health care and for the skilled services provided during the visit.</u></p> <p>On 1/25/13 at 5 PM, employee C indicated the record did not evidence the attending physician was consulted and a physician order received for admission to home care and for the services provided 1/18/13.</p> <p>4. Clinical record # 7, SOC 1/8/13, evidenced employee H, a registered nurse, completed the comprehensive assessment on 1/8/13. The comprehensive assessment included documentation that patient resided in a residential facility, had a gastrointestinal tube used for supplemental feedings at night, had a</p>		<p>2/15/13 2/15/13 This record will be fixed clinical record 5 by calling Md and receiving verbal order for services rendered. This will then be sent to the Md for Signing off of the order obtained. This will be completed the week of 2/15/2013. The employee will be directly responsible that did care to take the order to prevent this from re occurring in the future. The DON will provide oversight for this activity . 2/15/13</p> <p>This record will be fixed clinical record 6 by calling Md and receiving verbal order for services rendered. This will then be sent to the Md for Signing off of the order obtained. This will be completed the week of 2/15/2013. The employee will be directly responsible that did care to take the order to prevent this from re occurring in the future. The DON will provide oversight for this activity. 2/15/13</p> <p>This record will be fixed clinical record 7 by calling Md and receiving verbal order for services rendered. This will then be sent to the Md for Signing off of the order obtained. This will be completed the week of 2/15/2013. The employee will be directly responsible that did care to take the order to prevent this from re occurring in the future. The DON will provide oversight for this activity. 2/15/13 This policy was not met with the initiation of services post the</p>				

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	<p>indwelling urinary catheter for treatment of urinary retention, and medications were crushed and administered by the extended care staff. The record failed to evidence the registered nurse, or any one else from the agency, consulted with the attending physician and obtained physician order(s) to admit the patient to home health care and provide nursing services provided on 1/8/13 and the physical therapy services rendered on 1/9/13. The record evidenced a physician order to provide services was received on 1/10/13 after the patient had received skilled nursing and physical therapy services.</p> <p>On 1/25/13 at 5:05 PM employee B indicated the clinical record did not evidence the attending physician was consulted for admission to home care and orders were received for the services to be provided prior to skilled services rendered by agency staff.</p> <p>5. Clinical record # 8, SOC 1/21/13, evidenced employee N, a registered nurse, completed the comprehensive assessment on 1/21/13. The comprehensive assessment included documentation the registered nurse obtained a blood sample via a coagmeter for the evaluation of the patient's prothrombin time (how long it takes the blood to clot). The record failed to evidence the registered nurse, or</p>		<p>assessment was completed. Our agency will review this policy the week of 2/12/2012 with inservicing of all staff of the policy and testing on the proper protocol. All individuals will be required to receive a 100 percent or retesting will occur. To prevent this from being an issue in the future we will be placing this testing in our new hire education to prevent new hires from making this mistake. Our DON/ADON will be directly responsible for completing this by 2/15/2013. This record will be fixed clinical record 8 by calling Md and receiving verbal order for services rendered. This will then be sent to the Md for Signing off of the order obtained. This will be completed the week of 2/15/13 2/15/2013. The employee will be directly responsible that did care to take the order to prevent this from re occurring in the future. The DON will provide oversight for this activity. This record will be fixed clinical record 9 by calling Md and receiving verbal order for services rendered. This will then be sent to the Md for Signing off of the order obtained. This will be completed the week of 2/15/2013. The employee will be directly responsible that did care to take the order to prevent this from re occurring in the future. The DON will provide oversight for this activity. 7. This policy was not met with the initiation of services post</p>		

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	<p>any one else from the agency, consulted with the attending physician and obtained physician order(s) to admit the patient to home health care and to provide the nursing services rendered on 1/21/13.</p> <p>On 1/25/13 at 5:05 PM, employee C indicated the record did not evidence the attending physician was consulted for the admission to home care and for the services provided.</p> <p>6. Clinical record # 9, SOC 1/17/13, evidenced employee H, a registered nurse, completed the comprehensive assessment on 1/17/13. The comprehensive assessment included documentation the patient resided in a residential facility and states, "with intermittent confusion" and "left foot cleaned with NS [normal saline], absorbent foam cut in thin strip applied between 1st and second toe. Outer edge of 1st toe is noted with maceration and cracked open area noted bleeding measures 0.6 X [by] 0. 2. Under left first toe is noted with open area measuring 1 X 3 X 0.25 with moderate serosanguinous drainage noted. Areas noted to appear with fungal infection. SN [skilled nurse] to follow up with wound MD for new orders related to new areas." The record failed to evidence the registered nurse, or any one else from the agency, consulted with the attending</p>		<p>the assessment was completed. Our agency will review this policy the week of 2/12/2012 with inservicing of all staff of the policy and testing on the proper protocol. All individuals will be required to receive a 100 percent or retesting will occur. To prevent this from being an issue in the future we will be placing this testing in our new hire education to prevent new hires from making this mistake. Our DON/ADON will be directly responsible for completing this by 2/15/2013. In point ten of POC item 522 - In this situation, it appears the issue is when taking and writing verbal orders, they individual also needs to write the date in there order of when they took the verbal. Instead of it automatically filling it in by software it will need to be added to the note by clinicians. As the software then is only reporting the date the material was received in writing and not in verbal communication. We will be inservicing staff the week of Feb 15,2013 with testing with 100% required or re testing to be done. The ADON and DON are responsible for the above actions to be taken. They will then work with auditors and weekly verify that 100% of verbal orders had a verbal order date written as well in narrative section. We will repeat this for four consecutive weeks until 100 % of orders is received. It will then to prevent</p>		

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	<p>physician and obtained physician order(s) to admit the patient to home health care and to provide the nursing services rendered on 1/17/13.</p> <p>On 1/25/13 at 5:05 PM, employee B indicated the wound care order the nurse followed was dated 1/10/13 and was received by a physician from a wound care center. The record did not evidence the attending physician was consulted for the admission to home health care and for the nursing services provided.</p> <p>7. The policy titled Clinical / Service Data Collection" revision date April 2011 stated, "A clinical record / service record will be initiated and maintained for each patient receiving care or services ... and will include at a minimum: ... Physician orders and evidence of physician oversight activities. ... Entries into the clinical record will be made on the day care / service is provided to the patient."</p> <p>8. Clinical record #3 included patient consent for treatment date and a SOC date of 7-31-12. The record also provided a skilled nurse assessment dated 11-27-12 with a developed POC for the recertification period of 11-28-12 to 1-26-13. The record failed to evidence any physician orders prior to the care</p>		<p>future episodes go into our random audits required to be audited as well. If we fall below 90 percent we will go back into auditing all charts. 2/15/2013</p>		

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	<p>provided by physical therapy on 11-28-12, skilled nursing 12-5-12, and home health aide on 11-28-12.</p> <p>9. The April 2011 policy titled "Orders - Computer Access" states, "Verbal orders - if after 24 hours we have not received the face to face that has been completed or written orders that were sent. A phone call to MD to receive verbal orders is necessary. Explaining to MD why we need verbal orders may be needed. It is intakes responsibility to have main objectives for why homecare is needed. If we do not have HNP or other information yet, that is ok patient still needs to be started within the 48 hour time frame. The verbal order then needs to be cosigned by a nurse within the office before the patient is started and also meeting the deadline of signed by nurse end of everyday. Intake staff may take the verbal order from MD office, however, our internal nurse must sign off before care is initiated." (Sic)</p> <p>10. On 1-24-12 at 3:00 PM, the ADON indicated physician orders in the computer system are a 3 step process. The verbal order obtained by the the clinician is sent to the intake person who reviews it and then places it into the computer and it is</p>						

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	sent to the physician by the computer. The clinician then prompts the computer to send the order to the physician. The date of the order is created by the computer based on when the ordered was entered and not the date the order was received. Care is provided to the patient while this process is going on.			

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N0529	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record and policy review, the agency failed to ensure documentation evidenced the 60 day summary had been sent to the physician in 2 of 4 records reviewed of patients receiving care longer than 60 days with the potential to affect all patients receiving services longer than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 1, start of care (SOC) 8/26/11, failed to evidence a 60 day summary report had been sent to the physician for the certification period of 10/20/12 to 12/18/12. 2. Clinical record # 2, SOC 7/31/12, failed to evidence a 60 day summary report had been sent to the physician for the certification periods of 7/31/12 to 9/28/12 and 9/29/12 to 11/29/12. 3. The policy titled "Uniform Quality of Care and Quality Assessment" policy 	N0529	<p>Staff inservice week of 2/11/2013 inservice to consist of requirement for 60 day summary provided to physician if services are to continue. Upon each recertification, chart will be audited to assure 60 day summary sent to physician. Each recertification to be analyzed on weekly basis by DON/ADON/administrator. Expectation is to see 20% improvement weekly until 100% achieved by 3/20/2013.</p> <p>Clinical record 1,2 will have the 60 day report sent to the MD by the clinician writing the report on the date 2/15/13. The ADON is responsible for direct oversight of this activity. With auditing of these charts so that 100% accurate by that week end. To prevent this from happening in future all staff will be inserviced the same week and tested requiring a 100% or retested on the policy.</p>	02/16/2013			

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	number C:1-014.1 revision date April 2011 stated, "A written summary report for each patient will be sent to the patient's physician at least every 60 days."			

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N0565	<p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on clinical record and policy review and interview, the agency failed to ensure the plan of care was developed and included orders for treatment to be provided by the physical therapist prior to the provision of care in 1 (# 6) of 1 clinical record reviewed where the physical therapist completed the comprehensive assessment at the start of care with the potential to affect all patients receiving therapy services.</p> <p>The findings include:</p> <p>1. Clinical record # 6, start of care 1/18/13, evidenced employee J, a physical therapist, completed the comprehensive assessment on 1/18/13 and provided physical therapy services during the visit. The record failed to evidence the physical therapist, or any one else from the agency, consulted with the attending physician and obtained physician order(s) to admit the patient to home health care and for the skilled services provided during the visit.</p> <p>On 1/25/13 at 5 PM, employee C indicated the record did not evidence the attending physician was consulted and a</p>	N0565	<p>In this case rule 14 sec 1 c our therapist will be in serviced about calling physicians after the initial assessment and creating the appropriate plan of care and receiving verbal orders from MD. They will then take an exam on this protocol to prevent this error from occuring in future. These cases listed above then will then be corrected post the inservice the week of 2/11/2013 by the case manager informing the physician of the plan of care and getting verbal approval. This communication will be done on a new paper form titled " After assessment POC orders" until we figure out the issue in our software not documenting that this was done.</p> <p>2/15/2013 Then the DON will be responsible to meet with the auditors beginning friday 2/15/2013 to check each admission that the verbal orders were received to initiate all care for every patient We will be expecting 100 % compliance with this procedure beginning first week of 2/15/2013. To prevent future occurrences,</p>	02/15/2013	

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	<p>physician order received for admission to home care and for the services provided 1/18/13.</p> <p>2. The policy titled Clinical / Service Data Collection" revision date April 2011 stated, "A clinical record / service record will be initiated and maintained for each patient receiving care or services ... and will include at a minimum: ... Physician orders and evidence of physician oversight activities. ... Entries into the clinical record will be made on the day care / service is provided to the patient."</p>		<p>We will then require 4 weeks</p> <p>2/15/2013</p> <p>consecutively at 100 Percent correctness before this goes back into the random chart audits. If it falls below 90 percent with the random chart audits for orders after initial assessments then we will resume all chart audits until 4 consecutive weeks occur at 100%. The DON will be responsible for direct oversight of the above. In this case rule 14 sec 1 c</p> <p>our therapist will be in serviced about calling physicians after the initial assessment and creating the appropriate plan of care and receiving verbal orders from MD. They will then take an exam on this protocol to prevent this error from occurring in future.</p> <p>These cases listed above then will then be corrected post the inservice the week of 2/11/2013 by the case manager informing the physician of the plan of care and getting verbal approval. This communication will be done on a new paper form titled " After assessment POC orders" until we figure out the issue in our software not documenting that this was done.</p> <p>2/15/2013</p>		

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file and policy review, and interview, the agency failed to ensure the home health aide competency evaluation addressed all of the subject areas found at 410 IAC 17-14-1(h) for 4 (Files D, E, F, and G) of 4 home health aide files reviewed with the potential to affect all patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file D, date of hire 7/13/11, evidenced an untitled document which contained a list in a column that states, "HHA COMPETENCY, Proper Infection Control, Bag Technique, Bathing - tub / shower, Personal Care, HEP reminders, Medication Reminders, Documentation, and Vital signs." To the right of this list is two columns, one for the employee to fill out and states, "Initial / Date Self Evaluation of Skills" and the second</p>	N0596	<p>Current home health aids not on home health care registry will complete the competency evaluation program and be submitted to ISDH registry for home care aids by 3/20/2013. Ongoing upon hire, all home care aids will show proof of completion or complete the competency evaluation program prior to providing patient care services. This will be verified by human resources. DON/ADON/Administrator will additionally audit all HCA files for this verification prior to patient care. For all current staff and new hires. The competency testing will occur the week of 2/11/15 and be completed on all HCA not meeting criteria. They will then be registered with the state. This will be directly overviewed by DON/ADON. The entire process including the registering will be complete</p>	03/20/2013			

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	<p>column states, "Initial / Date Supervisor." The document evidenced the employee and a terminated registered nurse signed the document 7/13/11. The document failed to evidence the evaluation addressed each subject listed at 410 IAC 17-14-1(h) and failed to include 1) Communication; 2) Basic elements of body functioning and changes to be reported to a supervisor; 3) Maintaining a clean, safe, and healthy environment; 4) Recognizing emergencies and knowledge of emergency procedures; 5) The physical, emotional, and developmental needs of the ways to work with the population served by the home health agency; 6) Appropriate and safe techniques in personal hygiene and included a) Bed bath, b) Shampoo, c) Nail care, d) Oral hygiene, e) Toileting and elimination; 7) Safe transfer techniques and ambulation; 8) Normal range of motion and positioning; and 9) adequate nutrition and fluid intake.</p> <p>2. Personnel file E, date of hire 11/25/12, evidenced an untitled document which contained a list in a column that states, "HHA COMPETENCY, Proper Infection Control, Bag Technique, Bathing - tub / shower, Personal Care, HEP reminders, Medication Reminders, Documentation, and Vital signs." To the right of this list is two columns, one for the employee to</p>		<p>by 3/1/2013.</p> <p style="text-align: right;">3/1/2013</p> <p>In our first set of findings: Our home health aide competency program will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA not meeting the testing criteria. This will be done the week of 2/15/2012 with the DON and ADON responsible for this activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for monitoring all charts with 100% of all current and new hires to have competency exams completed by</p> <p style="text-align: right;">3/1/2013</p> <p>Personnel E findings: Our home health aide competency program will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA not meeting the testing criteria. This will be done the week of 2/15/2012 with the DON and ADON responsible for this</p>				

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	<p>fill out and states, "Initial / Date Self Evaluation of Skills" and the second column states, "Initial / Date Supervisor." The document evidenced the employee and a terminated registered nurse signed the document 7/13/11. The document failed to evidence the evaluation addressed each subject listed at 410 IAC 17-14-1(h) and failed to include 1) Communication; 2) Basic elements of body functioning and changes to be reported to a supervisor; 3) Maintaining a clean, safe, and healthy environment; 4) Recognizing emergencies and knowledge of emergency procedures; 5) The physical, emotional, and developmental needs of the ways to work with the population served by the home health agency; 6) Appropriate and safe techniques in personal hygiene and included a) Bed bath, b) Shampoo, c) Nail care, d) Oral hygiene, e) Toileting and elimination; 7) Safe transfer techniques and ambulation; 8) Normal range of motion and positioning; and 9) adequate nutrition and fluid intake.</p> <p>3. Personnel file F, date of hire 11/7/12, evidenced an untitled document which contained a list in a column that states, "HHA COMPETENCY, Proper Infection Control, Bag Technique, Bathing - tub / shower, Personal Care, HEP reminders, Medication Reminders, Documentation,</p>		<p>activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for montitoring all charts with 100% of all current and new hires to have compentency exams completed by 3/1/2013</p> <p>Our home health aide competency program will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA not meeting the testing criteria. This will be done the week of 2/15/2012 with the DON and ADON responsible for this activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for montitoring all charts with 100% of all current and new hires to have compentency exams completed by 3/1/2013</p> <p>personnel g finding: Our home health aide competency program</p>	

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	<p>and Vital signs." To the right of this list is two columns, one for the employee to fill out and states, "Initial / Date Self Evaluation of Skills" and the second column states, "Initial / Date Supervisor." The document evidenced the employee and a terminated registered nurse signed the document 7/13/11. The document failed to evidence the evaluation addressed each subject listed at 410 IAC 17-14-1(h) and failed to include 1) Communication; 2) Basic elements of body functioning and changes to be reported to a supervisor; 3) Maintaining a clean, safe, and healthy environment; 4) Recognizing emergencies and knowledge of emergency procedures; 5) The physical, emotional, and developmental needs of the ways to work with the population served by the home health agency; 6) Appropriate and safe techniques in personal hygiene and included a) Bed bath, b) Shampoo, c) Nail care, d) Oral hygiene, e) Toileting and elimination; 7) Safe transfer techniques and ambulation; 8) Normal range of motion and positioning; and 9) adequate nutrition and fluid intake.</p> <p>4. Personnel file G, date of hire 5/23/12, evidenced an untitled document which contained a list in a column that states, "HHA COMPETENCY, Proper Infection Control, Bag Technique, Bathing - tub /</p>		<p>will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA not meeting the testing criteria. This will be done the week of 2/15/2012 with the DON and ADON responsible for this activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for monitoring all charts with 100% of all current and new hires to have competency exams completed by 3/1/2013</p> <p>5. The Initial Competency Assessment Policy first will be reviewed and date added and accepted at next Pacc meeting mid march. This policy will then be reviewed with all HCA and management nurses in an in service week of 2/12/13</p> <p>Our home health aide competency program will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA</p>		

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	<p>shower, Personal Care, HEP reminders, Medication Reminders, Documentation, and Vital signs." To the right of this list is two columns, one for the employee to fill out and states, "Initial / Date Self Evaluation of Skills" and the second column states, "Initial / Date Supervisor." The document evidenced the employee and a terminated registered nurse signed the document 7/13/11. The document failed to evidence the evaluation addressed each subject listed at 410 IAC 17-14-1(h) and failed to include 1) Communication; 2) Basic elements of body functioning and changes to be reported to a supervisor; 3) Maintaining a clean, safe, and healthy environment; 4) Recognizing emergencies and knowledge of emergency procedures; 5) The physical, emotional, and developmental needs of the ways to work with the population served by the home health agency; 6) Appropriate and safe techniques in personal hygiene and included a) Bed bath, b) Shampoo, c) Nail care, d) Oral hygiene, e) Toileting and elimination; 7) Safe transfer techniques and ambulation; 8) Normal range of motion and positioning; and 9) adequate nutrition and fluid intake.</p> <p>5. The undated policy titled "Initial Competency Assessment" states, "The organization ensures that the competency</p>		<p>not meeting the testing criteria. This will be done the week of 2/15/2012 with the DON and ADON responsible for this activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for montitoring all charts with 100% of all current and new hires to have competency exams completed by</p> <p style="text-align: right;">3/1/2013</p>				

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	<p>of all personnel is assessed on hire, prior to providing care to organization patients."</p> <p>6. On 1/24/13 at 3 PM, employee B indicated the aides' competency of skills was completed by different registered nurses and only the skills required for the patient's visit were performed by the individual aide and assessed by the evaluating registered nurse. She indicated if the patient did not require the task, then the procedures for those tasks were discussed.</p>			

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel file review and interview, the agency failed to ensure home health aides were entered on and in good standing on the state aide registry for 3 of 4 home health aide files reviewed (D, E, and F) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file D, date of hire 7/13/11, failed to evidence the agency had checked to see if the employee was entered on and in good standing on the state aide registry. 2. Personnel file E, date of hire 11/23/12, failed to evidence the agency had checked to see if the employee was entered on and in good standing on the state aide registry. 3. Personnel file F, date of hire 11/7/12, failed to evidence the agency had checked to see if the employee was entered on and in good standing on the state aide registry. 4. On 1/24/13 at 3 PM, employee B indicated they were not aware that the aides were to be on the home health aide registry. 	N0597	<p>Upon hire all home care aids will show proof of home care aid certification. Agency will verify home care aid status is in good standing on ISDH registry prior to providing patient services. This will be verified by human resources. DON/ADON/Administrator will additionally audit employee file for this verification prior to patient care. Personnel file D,E,and F will be corrected by the end of 2/15/13 by running them through the state registry and checking there standing. If they were not in good standing they will then be terminated immediately. HR director will be responsible for this activity. To prevent this from occurring in the future this will be added to our pre screening with approval received from the candidate to run for this check. All charts will be 100% correct with in the week ending of 2/15/13. Our management staff will be educated on the requirement of the need to run the registry including Hr the week of 2/15/13. This will be completed by the ADM and testing will follow</p>	02/15/2013			

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			to make sure they are 100 Percent in understanding.	

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N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel file and policy review and interview the agency failed to ensure documentation evidenced the home health aide had completed a competency evaluation program prior to providing services for 4 of 4 home health aide (D, E, F, and G) and and the agency had verified the aide's status on the state aide registry in 3 of 4 home health aide files reviewed. (File D, E, and F) with the potential to affect all the patients of the agency that receive home health aide services.</p> <p>Findings include:</p> <p>Related to competency evaluation:</p> <ol style="list-style-type: none"> 1. Personnel file D, date of hire 7/13/11 failed to evidence the aide had completed a competency evaluation program that addressed all required subject areas. 2. Personnel file E, date of hire 11/23/12 failed to evidence the aide had completed a competency evaluation program that addressed all required subject areas. 3. Personnel file F, date of hire 11/7/12 	N0598	<p>Upon hire all home care aids will show proof of home care aid certification. Agency will verify home care aid status is in good standing on ISDH registry prior to providing patient services. This will be verified by human resources. DON/ADON/Administrator will additionally audit employee file for this verification prior to patient care. All HCA will be verified on state registry the week of 2/12/13 by HR director. Anyone not in good standing will then be terminated immediatley. Personnel file D,E,F, will also be checked at this time. To prevent this from happening in future, our HR Director will be running this test 100 % of time before hire on all new hires. This will continue now in our pre screening hire process and added to this week of</p> <p>2/15/2013Our home health aide competency program will be re updated to involve all necessary state requirements. This will be completed on 2/11/2013. After this document is then complete we will begin testing on all current HCA not meeting the testing criteria.</p>	03/01/2013			

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	<p>failed to evidence the aide had completed a competency evaluation program that addressed all required subject areas.</p> <p>4. Personnel file G, date of hire 5/23/12 failed to evidence the aide had completed a competency evaluation program that addressed all required subject areas.</p> <p>5. The undated policy titled "Initial Competency Assessment" states, "The organization ensures that the competency of all personnel is assessed on hire, prior to providing care to organization patients."</p> <p>6. On 1/24/13 at 3 PM employee B indicated the aides' competency of skills was completed by different registered nurses and only the skills required for the patient's visit were performed by the individual and assessed by the evaluating registered nurse.</p> <p>Related to the registry:</p> <p>1. Personnel file D, date of hire 7/13/11, failed to evidence the agency had checked to see if the employee was entered on and in good standing on the state aide registry.</p> <p>2. Personnel file E, date of hire 11/23/12, failed to evidence the agency had checked</p>		<p>This will be done the week of 2/15/2012 with the DON and ADON responsible for this activity. To prevent this from happening in future any individual that begins as a HCA with us that cannot show proof of a competency exam will be required to complete this before beginning patient care. The human resources director will be responsible for monitoring all charts with 100% of all current and new hires to have competency exams completed by</p> <p style="text-align: right;">3/1/2013</p> <p>Personnel file D,E,F, and G will be specifically targeted first to ensure they are competent in the above areas and the full competency is completed by 2/15/13</p>				

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	<p>to see if the employee was entered on and in good standing on the state aide registry.</p> <p>3. Personnel file F, date of hire 11/7/12, failed to evidence the agency had checked to see if the employee was entered on and in good standing on the state aide registry.</p> <p>4. On 1/24/13 at 3 PM, employee B indicated they were not aware that the aides were to be on the home health aide registry.</p>			

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N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure clinical records included a discharge summary for 1 (# 1) of 1 closed record reviewed creating the potential to affect all patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 10/28/12, included documentation by employee M, a licensed practical nurse, that evidenced the last services were rendered on 12/21/12. The record failed to evidence a discharge summary.</p>	N0608	<p>Staff inservice week of 2/11/2013 inservice to consist of requirement for 60 day summary provided to physician if services are to continue. Upon each discharge, the chart will be audited to assure discharge summary sent to physician. Each discharge to be analyzed on weekly basis by DON/ADON/administrator. Expectation is to see 20% improvement weekly until 100% achieved by 3/20/2013. This chart will be corrected with a dc summary entered as a late entry completed by 2/15/213 sent then to the MD for reviewal.</p>	03/20/2013			

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	2. On 1/24/13 at 11:52 AM, employee C indicated the record failed to evidence a discharge summary.		The DON is responsible to ensure this is completed by the date above. To prevent this from occurring in future the dc summary will be added to our QUAPI program to analyze and reduce the occurrence of this insidence with a 20 % improvement monthly until 100 % is achieved expecting to receive this result by 3/20/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157624		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER PHYSIOCARE HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 S EARL AVE STE 1A LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0612	<p>410 IAC 17-15-1(b) Clinical Records Rule 15 Sec. 1(b) Original clinical records shall be retained for the length of time as required by IC 16-39-7 after home health services are terminated by the home health agency. Policies shall provide for retention even if the home health agency discontinues operations.</p> <p>Based on policy review and interview, the agency failed to ensure there was a policy to provide for the retention of clinical records for a period of time required by IC 16-39-7 (7 years) in 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy dated April 2011 titled "Retention of Clinical / Service Records" states, "The clinical / service record will be retained for six (6) years after the provision of care / services unless otherwise stipulated by state or federal regulations. For minors, the seven (7) year retention requirement begins upon reaching the age of 18 unless law stipulates longer." On 1/25/13 at 6 PM, employee A indicated she was not aware the agency policy stated a six year retention. 	N0612	<p>Policy titled " retention of clinical records " has been revised to reflect a seven year period of retention. This policy will be reviewed and adopted in upcoming PAC meeting on 3/27/2013. The ADM was directly in charge of completing this tag. This will be prevented from occurring in future by adopting this policy and retaining records. No records have been taken out as we are a three year agency so no further action needed as all records are maintained.</p> <p>Policy titled " retention of clinical records " has been revised to reflect a seven year period of retention. This policy will be reviewed and adopted in upcoming PAC meeting on 3/27/2013. The ADM was directly in charge of completing this tag. This will be prevented from occurring in future by adopting this policy and retaining records. No records have been taken out as we are a three year agency so no further action needed as all records are maintained.</p> <p>All staff will be educated in the</p>	02/15/2013			

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			<p>next service of the new change of 7 years to the retention policy. The DON will be respponsable for holding the inservice the week of 2/15/2013.</p> <p>To prevent this from happening in future the staff will be notified now in training of the 7 year retention policy.</p>	