



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/07/2015
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N MERIDIAN ST STE 700 INDIANAPOLIS, IN 46204
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G 102 Bldg. 00	<p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on agency admission packet review and interview, the agency failed to ensure the written admission packet document, "Welcome to Home Care", provided to patients at start of care, clearly identified the rights of the home health agency patient for 1 of 1 home health agencies reviewed.</p> <p>Findings include:</p> <p>1. Agency admission packet titled "IU Health Home Care", 3/2011, contained a booklet titled "Welcome to Home Care" that stated, "5, Patients have the right to freely voice grievances and recommend changes in care or services without</p>	G 102	<p><b>G102, 484.10(a) (1) Notice of Rights</b> The IU Health Home Care Clinical Leadership Team reviewed the patient rights information included in the Admission packet and have replaced the document with home care specific language. (see attached document).The Clinical Leadership Team has provided written materials and in-serviced all clinical staff on 5-8-2015 and 5-11-2015. Effective 5-11-15, all home care patients will receive written information regarding patient rights prior to receiving care or during the initial evaluation visit before the initiation of care. All clinical staff will follow established processes and policies related to educating the patient about patient rights, providing the patient with written</p>	05/11/2015

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	<p>reprisal or unreasonable interruption of services ... You have the right for the hospital to provide language interpreting and translation services ... Pain management is part of medical treatment, both during your hospital stay and upon discharge ... Generally, you have the right to read your medical record while you are a patient in the hospital ... You have the right to talk privately with anyone you wish (subject to hospital visiting regulations) ... You will be instructed about how to continue your healthcare routine after you leave the hospital ... Information about your hospital bill ... You have the right to receive an explanation of your hospital bill ... You may ask hospital staff to give you information about financial help for your hospital bill ... Your responsibilities as a patient ... Your healthcare is a cooperative effort among you, your physician, and the hospital staff ... "</p> <p>2. On 4-7-15 at 11:30 A.M., the nursing supervisor, Employee C, indicated the adult patient admission packet contained all the written information provided to adult patients at start of care before services are furnished.</p> <p>3. On 4-7-15 at 4:00 PM, the manager of quality and health information management, Employee D,</p>		<p>notice of the patient rights, and documenting proof in the patient medical record. To ensure compliance, an audit of 10% of all clinical records per quarter will be conducted for 3 consecutive quarters for evidence that a written patient rights notice was provided to every patient prior to receiving care or during the initial evaluation visit before the initiation of care, with the expectation for compliance of 90% or greater. Any identified gaps will be discussed with staff on an individual basis and used for performance improvement. Spot audits will be conducted thereafter to assure sustained compliance. IU Health Home Health Care's Administrator/Clinical Manager will be responsible for monitoring this action plan to ensure that this deficiency is corrected and will not recur.</p>	

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G 176 Bldg. 00	<p>indicated the agency's written materials regarding patient rights and responsibilities were contained in the patient rights notice, verbally explained to patients prior to start of care, as found in the "Welcome to Home Care" booklet.</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.</p> <p>Based on clinical record review and interview, the agency failed to ensure all staff documented pertinent interactions with the patient's representative for 1 of 1 clinical records reviewed of patients who were discharged because of unsafe conditions for staff in the home (1).</p>	G 176	The Indiana University Health Home Care Clinical Leadership Team (Supervisors, Coordinators, & Clinical Manager) has provided written materials and in-serviced clinical staff in staff meetings on April 28th, April 29th, and plans to provide information and discuss in meetings scheduled May 5th and May 6th about documentation required in the	05/07/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record (CR) 1, start of care 3-6-14, contained a discharge summary and discharge OASIS/comprehensive assessment, dated 8-28-14, that evidenced the patient was discharged to caregiver on 8-28-14, without prior notice, due to verbal abuse from family member toward staff.</li> <li>2. On 4-7-15 at 3:00 PM, Employee B, staff RN, indicated she felt threatened by the behavior, tone, encroachment of personal space, and yelling of patient 1's family member on 8-28-14, 9 AM visit. She had gone to the residence for a scheduled visit after calling just prior to 8 AM to confirm the appointment. She indicated when she called to confirm the appointment, the family member of patient in clinical record 1 shouted at her over the phone, "There is no reason to call this early, do not ever do this again!" When she arrived about 9:00 AM, she completed the skilled nursing care for patient 1. Employee G determined to discharge patient 1 based on the behavior of the spouse while in the home. The clinical record stated, "Patient discharged from homecare due to threatening verbal behavior toward staff from [family member] ... " The clinical record evidenced Employee B, RN, provided the</li> </ol>		<p>patient's chart related to early discharge: the reason for early discharge, any pertinent interactions with the patient and/or patient representative, any unsafe conditions for staff in the patient's home, and written patient notification about discharging the patient early. Effective May 6th, 2015 all clinical staff will follow established practices of documenting about early discharge of a patient and written patient notification. 10% of all clinical records will be audited quarterly for evidence of documentation appropriate for early discharged patients. Any noncompliant staff will be provided additional education as needed. Indiana University Health Home Care's Clinical Manager will be responsible for monitoring this action plan to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>names of community resources to meet the patient's needs until the family member could make further arrangements.</p> <p>3. On 4-7-15 at 2:35 PM, Employee F, manager of Lafayette branch, indicated she called family member of patient in CR 1 on 8-28-14 after staff RN, Employee B, had reported the reason for discharge without notice of patient 1. An LPN, Employee E, had reported verbal abuse from patient 1's spouse when he refused to let her enter the home to provide care earlier in this episode of care. Employee F indicated the agency had not sent the patient/family member a letter summarizing the reasons for discharge and offering to assist the patient/family member with arrangements to meet the patient's continuing skilled and unskilled service needs. She stated she had called the home on 8-28-14 in the afternoon. The family member of patient 1 refused to talk to her, so she left a message, with a home health aide from an outside home health agency, to please have the family member contact the agency for any questions or needs of the patient. She indicated family member never returned her call. Employee F indicated her conversations, investigation, decision making, and actions pertaining to case management</p>			

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	<p>and the discharge without notice, of the patient in CR 1, for unsafe staff conditions, should have been documented in the clinical record, but she did not do so. She indicated a letter should have been sent to the patient/family member to inform the patient/family member of availability of assistance for continuity of care following the discharge without notice on 8-28-14. She indicated the patient became a client of the agency which had provided waiver service.</p> <p>4. On 4-7-14 at 4:00 PM, Employee D, manager of quality and health information management, indicated the agency should have mailed a written notice to patient 1/family member of patient 1, describing the reasons for the determination to end all services without notice and to offer to assist in finalizing arrangements for care to be transferred to another agency. She indicated the agency's reports had not detected this discharge without notice due to the proximity of the 8-28-14 discharge with the end of the certification period on 9-1-14. If the discharge had been identified in the reports as without 5 days notice, rather than discharged to caregiver, she would have followed up with a letter to patient/family member, notified the administrator, and documented all the agency actions related</p>			

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N 000 Bldg. 00	<p>to the discharge.</p> <p>5. On 4-7-15 at 4:30 PM, Employee C, nurse supervisor, indicated agency staff failed to document care management activities as required.</p> <p>This was a home health agency state complaint survey investigation.</p> <p>Complaint #: IN00155602 Unsubstantiated, lack of sufficient evidence. Unrelated state deficiencies are cited.</p> <p>Survey Date: April 7, 2015</p> <p>Facility Number: IN005333</p> <p>Medicaid Number: 200120720 A</p> <p>Parent and 2 branches:</p> <p>Census Service Type:: Skilled unduplicated admissions last 12 months 4,829 Home Health Aide only: 4 Total: 4,833</p>	N 000		

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N 494 Bldg. 00	<p>Current census:                      Skilled patients: 603                      Home Health Aide only: 4                      Total: 607</p> <p>QA:JE 04/22/15</p> <p>410 IAC 17-12-3(a)(1)&amp;(2)                      Patient Rights                      Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following:                      (1) Provide the patient with a written notice of the patient's right:                      (A) in advance of furnishing care to the patient; or                      (B) during the initial evaluation visit before the initiation of treatment.                      (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on agency admission packet review and interview, the agency failed to ensure the written admission packet document, "Welcome to Home Care", provided to patients at start of care,</p>	N 494	<b>N494, 410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights</b> The IU Health Home Care Clinical Leadership Team reviewed the patient rights information included in the Admission packet and have replaced the document with home	05/11/2015

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	<p>clearly identified the rights of the home health agency patient for 1 of 1 home health agencies reviewed.</p> <p>Findings include:</p> <p>1. Agency admission packet titled "IU Health Home Care", 3/2011, contained a booklet titled "Welcome to Home Care" that stated, "5, Patients have the right to freely voice grievances and recommend changes in care or services without reprisal or unreasonable interruption of services ... You have the right for the hospital to provide language interpreting and translation services ... Pain management is part of medical treatment, both during your hospital stay and upon discharge ... Generally, you have the right to read your medical record while you are a patient in the hospital ... You have the right to talk privately with anyone you wish (subject to hospital visiting regulations) ... You will be instructed about how to continue your healthcare routine after you leave the hospital ... Information about your hospital bill ... You have the right to receive an explanation of your hospital bill ... You may ask hospital staff to give you information about financial help for your hospital bill ... Your responsibilities as a patient ... Your healthcare is a cooperative effort among you, your</p>		<p>care specific language. (See attached document). The Clinical Leadership Team has provided written materials and in-serviced all clinical staff on 5-8-2015 and 5-11-2015. Effective 5-11-15, all home care patients will receive written information regarding patient rights prior to receiving care or during the initial evaluation visit before the initiation of care. All clinical staff will follow established processes and policies related to educating the patient about patient rights, providing the patient with written notice of the patient rights, and documenting proof in the patient medical record. To ensure compliance, an audit of 10% of all clinical records per quarter will be conducted for 3 consecutive quarters for evidence that a written patient rights notice was provided to every patient prior to receiving care or during the initial evaluation visit before the initiation of care, with the expectation for compliance of 90% or greater. Any identified gaps will be discussed with staff on an individual basis and used for performance improvement. Spot audits will be conducted thereafter to assure sustained compliance. IU Health Home Health Care's Administrator/Clinical Manager will be responsible for monitoring this action plan to ensure that this deficiency is corrected and will not recur.</p>	

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N 544 Bldg. 00	<p>physician, and the hospital staff ... "</p> <p>2. On 4-7-15 at 11:30 A.M., the nursing supervisor, Employee C, indicated the adult patient admission packet contained all the written information provided to adult patients at start of care before services are furnished.</p> <p>3. On 4-7-15 at 4:00 PM, the manager of quality and health information management, Employee D, indicated the agency's written materials regarding patient rights and responsibilities were contained in the patient rights notice, verbally explained to patients prior to start of care, as found in the "Welcome to Home Care" booklet.</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 clinical record review and interview, the agency failed to ensure all staff documented pertinent interactions with the patient's representative for 1 of 1 clinical records reviewed of patients who were discharged because of unsafe conditions for staff in the home (1).</p>	N 544	N544, 410 IAC 17-14-1(a)(1)(E) Scope of Services The IU Health Home Care Clinical Leadership Team (Supervisors, Coordinators, & Clinical Manager) has provided written materials and in-serviced clinical staff in staff meetings on April 28th, April 29th, and plans to provide information and discuss in meetings scheduled May 5th &	05/07/2015

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	<p>Findings include:</p> <p>1. Clinical record (CR) 1, start of care 3-6-14, contained a discharge summary and discharge OASIS/comprehensive assessment, dated 8-28-14, that evidenced the patient was discharged to caregiver on 8-28-14, without prior notice, due to verbal abuse from family member toward staff.</p> <p>2. On 4-7-15 at 3:00 PM, Employee B, staff RN, indicated she felt threatened by the behavior, tone, encroachment of personal space, and yelling of patient 1's family member on 8-28-14, 9 AM visit. She had gone to the residence for a scheduled visit after calling just prior to 8 AM to confirm the appointment. She indicated when she called to confirm the appointment, the family member of patient in clinical record 1 shouted at her over the phone, "There is no reason to call this early, do not ever do this again!" When she arrived about 9:00 AM, she completed the skilled nursing care for patient 1. Employee G determined to discharge patient 1 based on the behavior of the spouse while in the home. The clinical record stated, "Patient discharged from homecare due to threatening verbal behavior toward staff from [family member] ... " The clinical record evidenced Employee B, RN, provided the</p>		<p>May 6th about documentation required in the patient's chart related to early discharge: the reason for early discharge, any pertinent interactions with the patient and/or patient representative, any unsafe conditions for staff in the patient's home, and written patient notification about discharging the patient early. Effective May 6th, 2015 all clinical staff will follow established practices of documenting about early discharge of a patient &amp; written patient notification. 10% of all clinical records will be audited quarterly for evidence of documentation appropriate for early discharged patients. Any noncompliant staff will be provided additional education as needed. IU Health Home Care's Clinical Manager will be responsible for monitoring this action plan to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>names of community resources to meet the patient's needs until the family member could make further arrangements.</p> <p>3. On 4-7-15 at 2:35 PM, Employee F, manager of Lafayette branch, indicated she called family member of patient in CR 1 on 8-28-14 after staff RN, Employee B, had reported the reason for discharge without notice of patient 1. An LPN, Employee E, had reported verbal abuse from patient 1's spouse when he refused to let her enter the home to provide care earlier in this episode of care. Employee F indicated the agency had not sent the patient/family member a letter summarizing the reasons for discharge and offering to assist the patient/family member with arrangements to meet the patient's continuing skilled and unskilled service needs. She stated she had called the home on 8-28-14 in the afternoon. The family member of patient 1 refused to talk to her, so she left a message, with a home health aide from an outside home health agency, to please have the family member contact the agency for any questions or needs of the patient. She indicated family member never returned her call. Employee F indicated her conversations, investigation, decision making, and actions pertaining to case management</p>			

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	<p>and the discharge without notice, of the patient in CR 1, for unsafe staff conditions, should have been documented in the clinical record, but she did not do so. She indicated a letter should have been sent to the patient/family member to inform the patient/family member of availability of assistance for continuity of care following the discharge without notice on 8-28-14. She indicated the patient became a client of the agency which had provided waiver service.</p> <p>4. On 4-7-14 at 4:00 PM, Employee D, manager of quality and health information management, indicated the agency should have mailed a written notice to patient 1/family member of patient 1, describing the reasons for the determination to end all services without notice and to offer to assist in finalizing arrangements for care to be transferred to another agency. She indicated the agency's reports had not detected this discharge without notice due to the proximity of the 8-28-14 discharge with the end of the certification period on 9-1-14. If the discharge had been identified in the reports as without 5 days notice, rather than discharged to caregiver, she would have followed up with a letter to patient/family member, notified the administrator, and documented all the agency actions related</p>			

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	to the discharge.  5. On 4-7-15 at 4:30 PM, Employee C, nurse supervisor, indicated agency staff failed to document care management activities as required.				