

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER SERVANT'S HEART HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSPORT, IN 46947		
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G000000	<p>This visit was for a federal home health agency recertification survey. This was a partially extended survey.</p> <p>Survey Dates: June 19, 20, 21, 24, and 25, 2013.</p> <p>Facility #: 011301</p> <p>Medicaid Vendor # 200852690</p> <p>Surveyor: Tonya Tucker, RN, PHNS Team Leader Bridget Boston, RN PHNS</p> <p>QA: Linda Dubak, R.N. July 10, 2013</p>	G000000	<p>This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.</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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G000101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on clinical record review and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care prior to the beginning of care for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements. 	G000101	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient</p>	07/24/2013	

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			<p>signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months.</p> <p>After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000102	<p>484.10(a)(1) NOTICE OF RIGHTS</p> <p>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 clinical record review and interview, the agency failed to ensure the patient received written notice of the patient's rights in advance of care or during the initial evaluation visit before the initiation of treatment for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements. 	G000102	<p>CORRECTIVE ACTION TAKEN:</p> <p>This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA:</p> <p>Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office</p>	07/24/2013			

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			management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

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G000103	<p>484.10(a)(2) NOTICE OF RIGHTS The HHA must maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure documentation evidenced the patient was informed of all of his / her rights for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements. 	G000103	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient</p>	07/24/2013	

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			<p>signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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G000104	<p>484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. Based on clinical record review and interview, the agency failed to ensure the patient was informed of the right to exercise his / her rights for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements. 	G000104	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists</p>	07/24/2013			

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			<p>of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000106	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on clinical record review and interview, the agency failed to inform the patient and / or the patient's power of attorney was informed of the right to voice grievances regarding treatment or care that is or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and</p>	G000106	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet. This admission packet includes information regarding the patient's right to file a complaint, along with all other required patient right's information. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement</p>	07/24/2013			

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	<p>unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000107	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on interview and clinical record review, the agency failed to ensure the patient was informed that the home health agency was responsible to document the existence of complaints filed by the patient's family or legal representative regarding treatment or care that was or failed to be furnished, lack of respect for the patients property by anyone furnishing services on behalf of the agency, and to investigate and document the resolution of complaints for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to</p>	G000107	<p>CORRECTIVE ACTION TAKEN:</p> <p>This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet. This admission packet includes information regarding the patient's right for respect of their property and all other required information regarding patient rights. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA:</p> <p>Monthly chart audits will be done</p>	07/24/2013			

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G000108	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was advised in advance of care of the type and frequency of services to be provided for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	G000108	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities and the type and frequency of services to be provided. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE</p>	07/24/2013

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NAME OF PROVIDER OR SUPPLIER SERVANT'S HEART HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSFORT, IN 46947		
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	2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.		<p>DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights and all other required admission information has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000109	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was informed of their right to participate in the planning of the care and in the changes in the care and that the home health agency will advise the patient in advance of providing care of this right for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the 	G000109	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities (including their right to participate in the Plan of Care). A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator,</p>	07/24/2013

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	administrator indicated employee S required reeducation regarding admission requirements.		DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights and all other required admission information has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

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G000110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was informed of the agency's policies on advance directives and the Indiana Advance Directive Law for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of his / her Patient Rights when admitted to skilled services. The record contained admission documents from a previous admission and dated 4/25/12 and</p>	G000110	<p>CORRECTIVE ACTION TAKEN:</p> <p>This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities, along with our policies on advance directives and the Indiana Advance Directive Law. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork</p>	07/24/2013

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	<p>unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that our policies on advance directives and the Indiana Advance Directive Law and all other required admission information has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS</p>	

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			<p>PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure all services provided by the home health aide on behalf of the agency, were completed within accepted industry standards and followed infection control procedures during the provision of care for 1 of 2 home visit observations of a health health aide. (employee K)</p> <p>The findings include:</p> <p>1. During a home visit on June 20, 2013 at 9:10 AM, observed patient #1 without the ability to move independently and was dependent on employee K for all bed mobility and movement. The patient indicated she / he was bed bound for one year or more, only left the bed for medical care in a physician office or hospital, was only transferred from the bed by medical care attendants and a litter, and had not been out of bed in months. During the home visit, employee K was observed to perform range of motion exercises on the patient's lower extremities. During the the observation, the employee placed her hands just above the patients right knee</p>	G000121	<p>CORRECTIVE ACTION TAKEN: The aide involved with this deficiency was re-educated by the RN Case Manager on 7/16/13 regarding the following issues: 1. Following acceptable standards of care and Servant's Heart Services' policies regarding hand washing and changing gloves due to cross contamination issues while providing personal care for patients. 2. The scope of practice for aides when providing medication reminders, and how to accomplish this by involving the family or nurse with medication set up. She was instructed to never remove a medication from a bottle for a patient, and the importance of having the medications set up by the family and/or nurse prior to providing assistance to the patient. 3. She was given instruction regarding Range of Motion techniques, and observed providing appropriate ROM for the patient on this same date.4. The importance of following and documenting care according to the home health aide assignment sheet for every patient. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All home health aides will be given written in-services on</p>	08/01/2013
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	<p>and lifted the right upper leg, flexed the hip and the right knee at the same time. The employee completed 16 repetitions quickly within 20 seconds. She then held the right lower leg, below the knee, and moved the lower leg, below the knee joint, crossed the midline of the body and then the lower leg was moved outward from the body. The employee completed 18 of these adduction and abduction type repetitions. The range of motion was completed on the right leg within 40 seconds. She then moved to the left leg where these same movements were repeated in the same manner within 37 seconds. There was no warm up movements performed prior to the movements and the movements were completed quickly, without purpose. The body mechanics and alignment of the knee is flexion and extension. The knee does not normally rotate. A sign in the patient's bedroom stated, "Please do Range of Motion."</p> <p>The employee was observed to provide a bed bath and personal hygiene tasks. The patient was lying in a hospital bed. The employee repositioned the patient and placed on their left side. With gloved hands, the employee removed a incontinence brief from the patient, rolled the item and placed in a small trash receptacle, and then pushed down on the</p>		<p>the following topics: 1. Infection control/hand washing and cross contamination 2. Appropriate scope of service for home health aides, including medication reminders 3. Range of Motion techniques4. Performing and documenting care according to the home health aide assignment sheet for every patient. These in-services will be required to be completed by 8-1-13 and turned in to the Administrator. Any aide who does not achieve correct answers at 85% or higher will be given special one on one instruction and re-take the tests until 85% of the correct answers area accomplished. RN Case Managers will incorporate these same 4 topics as noted above with every supervisory visit for the next 12 months. (The Supervisory Visit form will be updated by 7-19-13 to include these issues.) In addition to the above interventions, every RN Case Manager will be assigned a team of aides (approximately 5 aides to each RN), and each aide will be required to:1. perform ROM2.demonstrate appropriate hand washing techniques3. provide documentation regarding the care provided according to the written home health aide assignment sheet for every patient4. demonstrate appropriate medication reminders as part of a regular skill checkoff. Other skills will also be observed (such as bathing, transferring,etc.) during</p>		

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	<p>item, gloved hand then in the trash can. Then, with the same gloved hand washed and dried the patients perineum and buttocks. The patient indicated a recent urinary infection treated with antibiotics within the last three (3) months.</p> <p>2. Clinical record #1 evidenced the patient was admitted for services, start of care 4/17/13 with diagnosis of multiple sclerosis, onset in 2005 and bed confinement since 3/31/11. The comprehensive assessment, dated 4/17/13 evidenced the patient was bed bound. The plan of care dated 4/17/13 through 6/15/13 stated, " HHA [home health aide] to assistance with all ... range of motion exercises."</p> <p>The document titled "Servant's Heart Home Health Services Home Health Aide Assignment Sheet" dated 10/19/12, 12/18/12, 2/14/13, 4/16/13, and 6/11/13. The assignment evidenced passive range of motion was to be performed daily on the patient's right and left leg and the left and right upper arm. The record failed to evidence specific range of motion exercises that were assigned and to be completed by the aide and observation of the aides while performing range of motion tasks to evaluate their performance and observation of infection control procedures to observed for</p>		<p>these check offs as well to ensure the aides are providing high quality care for their patients. These skill check offs will be done with each aide once every quarter (or 4 times per year) for a period of 1 year, and written reports will be submitted to the Administrator for each aide. Any aide who is not able to follow and/or understand these policies or demonstrate appropriate skills after being instructed will be reported to the Administrator by the RN Case Manager for possible termination of employment. If no further deficiencies are noted in these areas, the Supervisory visits will continue to highlight these three important areas (infection control, ROM, and scope of practice for aides) on a permanent basis.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>				

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	<p>breaches in infection control.</p> <p>3. Manual guide titled "Home Health Aide Training Manual" dated 1996 defined range of motion exercises as "The movement of an individuals joints through all of it's natural movements." Passive range of motion was defined as "The movement without the patient's participation."</p> <p>4. The undated policy titled "Hand Washing / Hand Hygiene D - 330" stated,"To reduce transmission of pathogenic microorganisms to patients and personnel in the home care setting. ... Appropriate antiseptic cleanser may be used when appropriate and patient situation facilities are not available. ... Indications for hand washing and hand antisepsis: ... Before caring for patients at high - risk for infection. When there is prolonged or intense contact with the patient (bathing the bathing.) [sic] Between tasks on the same patient. ... After removing gloves. After touching objects that are potentially contaminated."</p>			

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G000146	<p>484.14(h) SERVICES UNDER ARRANGEMENTS Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C 1495x(w)).</p> <p>Based on document review and interview, the agency failed to ensure a written contract between personnel under contract and the home health agency specified the manner in which services will be controlled and coordinated by the primary home health agency in 1 of 1 contracts reviewed with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A contract dated 10/29/2012 titled "Written Agreement for Home Care Contract Services" failed to evidence the manner in which services will be controlled and coordinated by the home health agency. 2. On 6/25/13 at 11:49, employee B indicated this was a new process and was unaware of the timeframe for contracted services to submit to the agency documentation following visit. 3. The undated agency policy titled "Contract Personnel D-460" states, 	G000146	<p>CORRECTIVE ACTION TAKEN: An addendum to the contract with Trinity Healthcare, Inc. (the contracting agency with Servant's Heart Home Health Services, Inc.) was written to state that the contracted staff will fax their visit notes to the Servant's Heart's office and mail the original documents within 7 days. This addendum was faxed to Trinity Healthcare, Inc. and signed by their appropriate manager as well as by Servant's Heart Home Health Services, Inc. administrator's signature to confirm this written agreement.</p> <p>PLAN TO PREVENT FUTURE DEFICIENCIES IN THIS AREA: Going forward, all contracts will be reviewed to ensure that the written agreement between the contracted personnel and Servant's Heart Services specifies <u>in writing</u> the manner in which services will be controlled and coordinated and not be based only on a verbal understanding. PERSON RESPONSIBLE FOR THIS CORRECTION: The Administrator and/or Assistant Administrator</p>	07/15/2013

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	<p>"Special Instructions ... 2. Contract personnel or organizations shall execute a written agreement, including charges, with Servant's Heart Home Health Services outlining the rules governing professional services rendered by contracted personnel ... a. The written agreement, signed by both parties, shall minimally include, but not be limited to: ... Procedures for submitting clinical notes, scheduling of visits and conducting periodic patient evaluation."</p> <p>4. On 6/25/13 at 12:20 PM, employee A indicated the home health agency and the contracted agency have a verbal agreement after therapy visits have been made, the contracted agency will fax the visit notes to the office and mail the documents to the agency within 7 days.</p>				

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review, observation and interview, the agency failed to ensure the physician ordered plan of care included the specific interventions to be provided by the individuals providing aide services on behalf of the agency for 1 (# 1) of 9 records reviewed of current patients that received aide services and failed to ensure skilled services were provided as ordered 1 of 7 (# 10) current records with orders for a skilled nurse, creating the potential to affect all of the agency's current patients that received skilled nurse and aide services.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 evidenced the patient was admitted for services with diagnosis of multiple sclerosis, onset in 2005 and bed confinement since 3/31/11. The comprehensive assessment dated 4/17/13 evidenced the patient was bed bound and had contracture's of the hands bilaterally. The plan of care, established by the physician for the certification periods</p>	G000158	<p>CORRECTIVE ACTION TAKEN: The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of updating the Plan of Care and obtaining a signed order by the physician to document when any visit is cancelled. All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. Instructions will be given to RN's to ensure that all home health aide assignment sheets accurately reflect a complete description of the aide's services, and that those services are noted on the Plan of Care as well. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All home health aides will be given written in-services on the following topics: 1. Infection control/hand washing and cross contamination 2. Appropriate scope of service for home health aides, including medication reminders 3. Range of Motion techniques 4. Performing and documenting care according to the home health aide assignment sheet for every patient. These</p>	07/24/2013			

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	<p>dated 4/17/13 through 6/15/13 and 6/16/13 through 8/14/13 stated, "HHA 5 week 9 [five times a week for 9 weeks] ... to assist with all bathing, hygiene needs, grooming, repositioning Q2HRS [every 2 hours] as tolerated by patient, ... meal prep and feeding, range of motion exercises and medication reminders X [times] 60 days."</p> <p>A. The record evidenced a document titled "Servant's Heart Home Health Services Home Health Aide Assignment Sheet" dated 10/19/12, 12/18/12, 2/14/13, 4/16/13, and 6/11/13. The aide assignment evidenced directions to assist the patient with medication at 9 AM, 5 PM, and at bedtime. The assignment failed to evidence specifically how the aide was to assist the patient with medications. The directions failed to direct the aide to remove one 400 milligram neurontin capsule and to administer to the patient and failed to direct the aides to reposition the patient every 2 hours as ordered on the plan of care.</p> <p>B. The record evidenced document titled "Home Health Aide Notes" documented by the individual completing the daily services and evidenced employees F, H, I, K, L, and M provided aide services between 4/17/13 through 6/19/13 and</p>		<p>in-services will be required to be completed by 8-1-13 and turned in to the Administrator. Any aide who does not achieve correct answers at 85% or higher will be given special one on one instruction and re-take the tests until 85% of the correct answers area accomplished. RN Case Managers will incorporate these same 4 topics as noted above with every supervisory visit for the next 12 months. (The Supervisory Visit form will be updated by 7-19-13 to include these issues.) In addition to the above interventions, every RN Case Manager will be assigned a team of aides (approximately 5 aides to each RN), and each aide will be required to: 1. perform ROM 2.demonstrate appropriate hand washing techniques 3. provide documentation regarding the care provided according to the written home health aide assignment sheet for every patient 4. demonstrate appropriate medication reminders as part of a regular skill checkoff. Other skills will also be observed (such as repositioning, bathing, transferring,etc.) during these check offs as well to ensure the aides are providing high quality care of or their patients. These skill check offs will be done with each aide once every quarter (or 4 times per year) for a period of 1 year,and written reports will be submitted to the Administrator for each aide. Any aide who is not</p>				

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	<p>documented by the individual completing the aide services. The aide visit notes reviewed failed to evidence documentation that the aide provided the change of position and repositioning every two hours as ordered or why the task was not completed and documented medication reminders were performed daily.</p> <p>C. Employee F provided aide services on June 11, 13, and 14, 2013. The visit notes failed to evidence range of motion was completed and why the task was not completed.</p> <p>D. Employee L provided aide services on June 8, 2013 and failed to evidence range of motion was completed and why the task was not completed.</p> <p>2. On June 19, 2013 at 4 pm, Employee A indicated patient 1 had no independent mobility and not able to move their little finger.</p> <p>3. During a home visit on June 20, 2013 at 9:10 AM, observed patient #1 without the ability to move independently and was dependent on employee L for all bed mobility and movement. Employee L and the patient indicated the aides that provide services to the patient, retrieve the patient's medications from a pre-set</p>		<p>able to follow and/or understand these policies or demonstrate appropriate skills after being instructed will be reported to the Administrator by the RN Case Manager for possible termination of employment. If no further deficiencies are noted in these areas, the Supervisory visits will continue to highlight these three important areas (infection control, ROM, and scope of practice for aides) on a permanent basis. The Performance Improvement Committee will audit ten (10) client records each month for a period of three (3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Cares will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers(the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of</p>				

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	<p>medication container twice a day, they place the medications in a small container and then place the container to the patients lips, the patient allows the employees to place the medications in his / her mouth and then the patient is given fluids by straw to assist with swallowing. The employee indicated daily at 5 PM, the aide on duty was to retrieve a 400 milligram neurontin capsule from a prescription bottle and administer this medication following the same procedure. Patient 1 confirmed that the staff place medication in his / her mouth and when asked, the patient indicated to not know what the medication administered at 5 PM was to treat. When asked, the patient indicated the aide on duty routinely give medications after they arrive in the morning around 9 AM, at 5 PM, and just before they leave in the evening, between 9 - 10 PM. The patient indicated if the aides leave before 9 PM, then a family member administer the night time medications. The patient indicated employee L administered the oral medications on the morning of 6/20/13 prior to the arrival of the surveyor. The employee indicated the patient requires feeding and was not capable of using finger to place anything in the mouth.</p> <p>4. Clinical record #10, start of care (SOC) 11/21/11, included a plan of care</p>		correction to ensure no further deficiencies in this area occur.	

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	<p>for the certification period 3/14/13 through 5/13/13 with orders for skilled nurse visits once a week for 3 weeks to preset the patient's medications. The record evidenced the skilled nurse conducted a nurse visit and assisted the patient's family member to prepare the patients medications on 3/13/13 and then returned on 3/21/13. The record failed to evidence the skilled nurse visits were made as ordered on the plan of care of a physician order to discontinue the previous skilled nurse visit order.</p> <p>On 6/19/13 at 3 PM the administrator indicated the skilled nurse visits were not made as ordered on the plan of care dated 3/14/13.</p> <p>5. The undated policy titled "Care Plans C - 660" stated, "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals. Following the initial assessment, a care plan shall be developed with the client and / or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care. ... The care plan shall include, but not be limited to: ... A</p>			

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	<p>list of specific interventions with plans for implementation</p> <p>6. The undated policy titled "Plan of Care / Doctor's Orders C - 580" stated, "Verbal / telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>7. The undated policy titled "Physician's Orders C - 635" stated, "All medications, treatment and services provided to clients must be ordered by a physician. Orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatment, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... Purpose - To document verification that orders for services have been obtained from the physician."</p>						

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G000160	<p>484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the physician was consulted to approve additions or modifications to the plan of care in 1 (# 10) of 9 current clinical records reviewed of patients skilled services with the potential to affect all current patients.</p> <p>The findings include:</p> <p>1. Clinical record #10, start of care 11/21/11, included a plan of care for the certification period 3/14/13 through 5/13/13 with orders for skilled nurse visits once a week for 3 weeks to preset the patient's medications. The record evidenced the skilled nurse conducted a nurse visit and assisted the patient's family member to prepare the patients medications on 3/13/13 and then returned on 3/21/13. The record failed to evidence the skilled nurse visits were made as ordered on the plan of care of a physician order to discontinue the previous skilled nurse visit order.</p> <p>On 6/19/13 at 4:30 PM the administrator</p>	G000160	<p>CORRECTIVE ACTION TAKEN: The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of updating the Plan of Care and obtaining a signed order by the physician to document when a visit is cancelled. An order was faxed to the physician on this date to notify him of the SN visit that was cancelled. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All nursing staff will attend an in-service on 7-24-13 and be re-educated by the Administrator on the importance of providing services as ordered by the physician on the Plan of Care. The Performance Improvement Committee will audit ten (10) client records each month for a period of three(3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Care will occur until no further problems</p>	07/24/2013
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	<p>indicated the skilled nurse visits were not made as ordered on the plan of care dated 3/14/13 and there was not an order to discontinue the skilled nurse visits.</p> <p>2. The undated policy titled "Plan of Care / Doctor's Orders C - 580" stated, "Verbal / telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>3. The undated policy titled "Physician's Orders C - 635" stated, "All medications, treatment and services provided to clients must be ordered by a physician. Orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatment, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... Purpose - To document verification that orders for services have been obtained from the physician."</p>		<p>are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse (RN) had provided treatments as ordered by the physician in 1 (# 10) of 8 current clinical records reviewed with orders for skilled nurse services with the potential to affect all current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #10, start of care 11/21/11, included a plan of care for the certification period 3/14/13 through 5/13/13 with orders for skilled nurse visits once a week for 3 weeks to preset the patient's medications. The record evidenced the skilled nurse conducted a nurse visit and assisted the patient's family member to prepare the patients medications on 3/13/13 and then returned on 3/21/13. The record failed to evidence the skilled nurse visits were made as ordered on the plan of care or a physician order to discontinue the previous skilled nurse visit order. <p>On 6/19/13 at 4:30 PM the administrator indicated the skilled nurse visits were not made as ordered on the plan of care dated 3/14/13 and there was not an order to</p>	G000170	<p>CORRECTIVE ACTION TAKEN: The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of updating the Plan of Care and obtaining a signed order by the physician to document when a visit is cancelled. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. The nurses will be informed regarding the importance of adhering to our policy regarding obtaining a physician's order if any services are changed or cancelled on the Plan of Care . The Performance Improvement Committee will audit ten (10) client records each month for a period of three (3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Cares</p>	07/24/2013			

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	<p>discontinue the order for the skilled nurse.</p> <p>2. The undated policy titled "Plan of Care / Doctor's Orders C - 580" stated, "Verbal / telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>3. The undated policy titled "Physician's Orders C - 635" stated, "All medications, treatment and services provided to clients must be ordered by a physician. Orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatment, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... Purpose - To document verification that orders for services have been obtained from the physician."</p>		<p>will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000176	<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 and policy review, and interview, the agency failed to ensure the registered nurse prepared clinical notes in 1 of 9 active patients records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 start of care date 5/3/13, contained a plan of care for certification period 5/3/13 to 7/1/13 which states, "21. SN: 1Month2:9 as needed 9: skilled nurse observation and assessment of cardiovascular and respiratory status, SN to assess vital signs including SPO2 and all body systems, medication compliance, monitor for edema, weight gain and signs and symptoms of complications. SN to instruct in disease progresses, medication regimen and compliance, falls precautions, bleeding precautions, and signs and symptoms to report. SN to set up medication planner every 4 weeks. SN to obtain labs as ordered by physician. SN 1 visit per week PRN changes in medications that require a change in</p>	G000176	<p>CORRECTIVE ACTION TAKEN: The RN involved with this deficiency was re-educated on 6-25-13 by the Administrator on the importance of documenting lab results and all other pertinent patient information in the patient's chart. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All nursing staff will attend an in-service on 7-24-13 and be re-educated by the Administrator on the importance of documenting lab results and all other pertinent patient information in the patient's chart. The form used for Skilled Nursing visits will be revised by 7-24-13 to include specific areas to document when labs are drawn, what lab was ordered, and the results of the lab in order to make it easier to document these findings. This new form will be distributed to the RN's at the in-service scheduled on 7-24-13. A log for all patient lab draws will be maintained by the Director of Nurses and monitored by the Administrator. The Performance Improvement Committee will audit all charts listed on this log each month for a period of three (3) months to ensure they are documented in the patient's file along with the lab</p>	07/24/2013			

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	<p>medication box before next scheduled visit for change in patients condition. ...</p> <p>22A. the patient's INR Lab value will be within normal limits per physician assessment and patient's compliance with meds/diet X 60 days."</p> <p>A. A document completed by employee B (Nursing Supervisor) dated 5/3/13 titled "Nursing admission Assessment Form" states, "Hx of past illnesses/hospitalizations/past surgeries: Hx afib, HTN, arthritis, long term use coumadin, next lab draw 6/4/13."</p> <p>B. A document completed by employee B dated 6/4/13 titled "Nursing Assessment Form" states, "SKILLED/INTERVENTIONS/TEACHING: Medication planner (4 weeks) set up completed. reminded pt due for PT/INR-prefers to have done @ VA; will go tomorrow.</p> <p>C. The record failed to evidence documentation of lab work performed or results/values reported to the agency.</p> <p>2. On 6/24/13 at 3:30 PM, employee B indicated receiving a call with the patients results as within normal limits but indicated no documentation was made of the call or the results in the patient record.</p>		<p>results. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the nurses' documentation will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>				

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	3. The undated agency policy titled "Clinical Records/Medical Record Retention C-870" states, "Special Instructions Clinical Record: ... 5. Documentation shall establish that effective interchange, reporting, and coordination of client care does occur."			

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G000224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record and policy review, observation and interview, the agency failed to ensure written home health aide instructions included services that were ordered by the physician and on the plan of care in 1 (# 1) of 2 records reviewed of current patients with home health aide home visit observation creating the potential to affect all of the agency's current patients whom receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 evidenced the patient was admitted for services with diagnosis of multiple sclerosis, onset in 2005 and bed confinement since 3/31/11. The comprehensive assessment dated 4/17/13 evidenced the patient was bed bound and had contracture's of the hands bilaterally. The plan of care, established by the physician for the certification periods dated 4/17/13 through 6/15/13 and 6/16/13 through 8/14/13 stated, "HHA 5 week 9 [five times a week for 9 weeks] ...</p>	G000224	<p>CORRECTIVE ACTION TAKEN:</p> <p>All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. Instructions will be given to RN's to ensure that all home health aide assignment sheets accurately reflect a complete description of the aide's services, and that those services are noted on the Plan of Care as well. The aide involved with this deficiency was re-educated by the RN Case Manager on 7/16/13 regarding the following issues: 1. Following acceptable standards of care and Servant's Heart Services' policies regarding hand washing and changing gloves due to cross contamination issues while providing personal care for patients. 2. The scope of practice for aides when providing medication reminders, and how to accomplish this by involving the family or nurse with medication setup. She was instructed to never remove a medication from a bottle for a patient, and the importance of having the</p>	07/24/2013

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	<p>to assist with all bathing, hygiene needs, grooming, repositioning Q2HRS [every 2 hours] as tolerated by patient, ... meal prep and feeding, range of motion exercises and medication reminders X [times] 60 days."</p> <p>A. The record evidenced a document titled "Servant's Heart Home Health Services Home Health Aide Assignment Sheet" dated 10/19/12, 12/18/12, 2/14/13, 4/16/13, and 6/11/13. The aide assignment evidenced directions to assist the patient with medication at 9 AM, 5 PM, and at bedtime. The assignment failed to evidence specifically how the aide was to assist the patient with medications. The directions failed to direct the aide to remove one 400 milligram neurontin capsule and to administer to the patient and failed to direct the aides to reposition the patient every 2 hours as ordered on the plan of care.</p> <p>B. The record evidenced document titled "Home Health Aide Notes" documented by the individual completing the daily services and evidenced employees F, H, I, K, L, and M provided aide services between 4/17/13 through 6/19/13 and documented by the individual completing the aide services. The aide visit notes reviewed failed to evidence</p>		<p>medications set up by the family and/or nurse prior to providing assistance to the patient. 3. She was given instruction regarding Range of Motion techniques, and observed providing appropriate ROM for the patient on this same date. 4. The importance of following and documenting care according to the home health aide assignment sheet for every patient. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All home health aides will be given written in-services on the following topics: 1. Infection control/hand washing and cross contamination 2. Appropriate scope of service for home health aides, including medication reminders 3. Range of Motion techniques 4. Performing and documenting care according to the home health aide assignment sheet for every patient. These in-services will be required to be completed by 8-1-13 and turned in to the Administrator. Any aide who does not achieve correct answers at 85% or higher will be given special one on one instruction and re-take the tests until 85% of the correct answers area accomplished. RN Case Managers will incorporate these same 4 topics as noted above with every supervisory visit for the next 12 months. (The Supervisory Visit form will be updated by 7-19-13 to include these issues.) In addition to the above interventions, every RN Case</p>				

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	<p>documentation that the aide provided the change of position and repositioning every two hours as ordered or why the task was not completed and documented medication reminders were performed daily.</p> <p>C. Employee F provided aide services on June 11, 13, and 14, 2013. The visit notes failed to evidence range of motion was completed and why the task was not completed.</p> <p>D. Employee L provided aide services on June 8, 2013 and failed to evidence range of motion was completed and why the task was not completed.</p> <p>2. On June 19, 2013 at 4 pm, Employee A indicated the patient had no independent mobility and stated, "Not even his / her little finger."</p> <p>3. During a home visit on June 20, 2013 at 9:10 AM, observed patient 1 without the ability to move independently and was dependent on employee L for all bed mobility and movement. Employee L and the patient indicated the aides that provide services to the patient, retrieve the patient's medications from a pre-set medication container twice a day, they place the medications in a small container and then place the container to the</p>		<p>Manager will be assigned a team of aides (approximately 5 aides to each RN), and each aide will be required to: 1. perform ROM 2.demonstrate appropriate hand washing techniques 3. provide documentation regarding the care provided according to the written home health aide assignment sheet for every patient 4. demonstrate appropriate medication reminders as part of a regular skill checkoff. Other skills will also be observed (such as bathing, transferring,etc.) during these check offs as well to ensure the aides are providing high quality care for their patients. These skill check offs will be done with each aide once every quarter (or 4 times per year) for a period of 1 year,and written reports will be submitted to the Administrator for each aide. Any aide who is not able to follow and/or understand these policies or demonstrate appropriate skills after being instructed will be reported to the Administrator by the RN Case Manager for possible termination of employment. If no further deficiencies are noted in these areas, the Supervisory visits will continue to highlight these three important areas (infection control, ROM, and scope of practice for aides) on a permanent basis. The Performance Improvement Committee will audit ten (10) client records each month for a period of three (3) months to</p>		

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	<p>patients lips, the patient allows the employees to place the medications in his / her mouth and then the patient is given fluids by straw to assist with swallowing. The employee indicated daily at 5 PM, the aide on duty was to retrieve a 400 milligram neurontin capsule from a prescription bottle and administer this medication following the same procedure. Patient #1 confirmed that the staff place medication in his / her mouth and when asked, the patient indicated to not know what the medication administered at 5 PM was to treat. When asked, the patient indicated the aides generally give medications after they arrive in the morning around 9 AM, at 5 PM, and just before they leave in the evening, between 9 - 10 PM. The patient indicated if the aides leave before 9 PM, then a family member administer the night time medications. The patient indicated employee L administered the oral medications on the morning of 6/20/13 prior to the arrival of the surveyor. The employee indicated the patient requires feeding and was not capable of using finger to place anything in the mouth.</p> <p>4. The undated policy titled "Home Health Aide Plan of Care C 760" stated, "A complete and appropriate care plan, identifying duties to be performed by the home health aide, shall be developed by a</p>		<p>ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. We will also ensure that the aides are documenting care according to the patient's Home Health Aide assignment sheet, and that assignment sheet appropriately reflects what is ordered on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Care will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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	<p>registered nurse or therapist. All home health aide staff will follow the identified plan. ... The personal care plan shall be developed in plan, non technical terms and identify the duties to be performed such as, not limited to; a. Personal care. b. Ambulation and exercise. ... d. assistance with medications that are ordinarily self administered."</p>			

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G000225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review, home observation and interview, the agency failed to ensure the aide did not administer medications, which is outside the aide's scope of practice, for 1 (1) of 2 clinical records reviewed and failed to ensure direct care was provided to the patient as ordered on the plan of care in 1 of 5 current clinical records reviewed with orders for skilled nursing and home health aide services (9), with the potential to affect all patients receiving home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 evidenced the patient was admitted for services with diagnosis of multiple sclerosis, onset in 2005 and bed confinement since 3/31/11. The comprehensive assessment dated 4/17/13 evidenced the patient was bed bound and had contracture's of the hands bilaterally. The plan of care, established by the physician for the certification periods dated 4/17/13 through 6/15/13 and 6/16/13 through 8/14/13 stated, "HHA 5</p>	G000225	<p>CORRECTIVE ACTION TAKEN:</p> <p>The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of the home health aide assignment sheet being thorough and including important instructions regarding things such as repositioning the patient, range of motion, medication reminders, etc. All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. Instructions will be given to RN's to ensure that all home health aide assignment sheets accurately reflect a complete description of the aide's services, and that those services are noted on the Plan of Care as well. The aide involved with this deficiency was re-educated by the RN Case Manager on 7/16/13 regarding the following issues: 1. Following acceptable standards of care and Servant's Heart Services' policies regarding hand washing and changing gloves due to cross contamination issues while providing personal care for patients. 2. The scope of practice for aides when providing</p>	08/01/2013
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	<p>week 9 [five times a week for 9 weeks] ... to assist with all bathing, hygiene needs, grooming, repositioning Q2HRS [every 2 hours] as tolerated by patient, ... meal prep and feeding, range of motion exercises and medication reminders X [times] 60 days." The clinical record failed to evidence the individual responsible for medication management and who and how the medications would be administered to the patient.</p> <p>A. The record evidenced a document titled "Servant's Heart Home Health Services Home Health Aide Assignment Sheet" dated 10/19/12, 12/18/12, 2/14/13, 4/16/13, and 6/11/13. The aide assignment evidenced directions to assist the patient with medication at 9 AM, 5 PM, and at bedtime. The assignment failed to evidence specifically how the aide was to assist the patient with medications and failed to instruct the aide to change the patients position frequently or every two hours as stated on the medical plan of care.</p> <p>B. The record evidenced documents titled "Home Health Aide Notes" which the individuals completing the daily home health aide services, employees F, H, I, K, L, and M, documented individually the aide services they each provided between 4/17/13 through 6/19/13. The aide visit</p>		<p>medication reminders, and howto accomplish this by involving the family or nurse with medication setup. She was instructed to never remove a medication from a bottle for a patient, and the importance of having the medications set up by the family and/or nurse prior to providing assistance to the patient. 3. She was given instruction regarding Range of Motion techniques, and observed providing appropriate ROM for the patient on this same date. 4. The importance of following and documenting care according to the home health aide assignment sheet for every patient. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All home health aides will be given written in-services on the following topics: 1. Infection control/hand washing and cross contamination 2. Appropriate scope of service for home health aides, including medication reminders 3. Range of Motion techniques 4. Performing and documenting care according to the home health aide assignment sheet for every patient. These in-services will be required to be completed by 8-1-13 and turned in to the Administrator. Any aide who does not achieve correct answers at 85%or higher will be given special one on one instruction and re-take the tests until85% of the correct answers area accomplished. RN Case Managers will incorporate these</p>				

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	<p>notes reviewed failed to evidence documentation that the aide provided the change of position and repositioning every two hours as ordered or why the task was not completed. The documents evidenced medication reminders were performed daily by the aide whom provided the aide services.</p> <p>C. Employee F provided aide services on June 11, 13, and 14, 2013. The visit notes failed to evidence range of motion was completed and why the task was not completed.</p> <p>D. Employee L provided aide services on June 8, 2013 and failed to evidence range of motion was completed and why the task was not completed.</p> <p>2. During a home visit on June 20, 2013 at 9:10 AM, observed patient #1 without the ability to move independently and was dependent on employee L for all bed mobility and movement. Employee L and the patient indicated the aides that provide services to the patient, retrieve the patient's medications from a pre-set medication container twice a day, they place the medications in a small container and then place the container to the patients lips, the patient allows the employees to place the medications in his / her mouth and then the patient is given</p>		<p>same 4 topics as noted above with every supervisory visit for the next 12 months. (The Supervisory Visit form will be updated by 7-19-13 to include these issues.) In addition to the above interventions, every RN Case Manager will be assigned a team of aides (approximately 5 aides to each RN), and each aide will be required to: 1. perform ROM 2.demonstrate appropriate hand washing techniques 3. provide documentation regarding the care provided according to the written home health aide assignment sheet for every patient 4. demonstrate appropriate medication reminders as part of a regular skill check off. Other skills will also be observed (such as bathing, transferring, etc.) during these check offs as well to ensure the aides are providing high quality care for their patients. These skill check offs will be done with each aide once every quarter (or 4 times per year) for a period of 1 year,and written reports will be submitted to the Administrator for each aide. Any aide who is not able to follow and/or understand these policies or demonstrate appropriate skills after being instructed will be reported to the Administrator by the RN Case Manager for possible termination of employment. If no further deficiencies are noted in these areas, the Supervisory visits will continue to highlight these four</p>				

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	<p>fluids by straw to assist with swallowing. The employee indicated daily at 5 PM, the aide on duty was to retrieve a 400 milligram neurontin capsule from a prescription bottle and administer this medication following the same procedure. Patient #1 confirmed that the staff place medication in his / her mouth and when asked, the patient indicated to not know what the medication administered at 5 PM was to treat. When asked, the patient indicated the aides generally give medications after they arrive in the morning around 9 AM, at 5 PM, and just before they leave in the evening, between 9 - 10 PM. The patient indicated if the aides leave before 9 PM, then a family member administer the night time medications. The patient indicated employee L administered the oral medications on the morning of 6/20/13 prior to the arrival of the surveyor. The employee indicated the patient requires feeding and was not capable of using finger to place anything in the mouth.</p> <p>3. Clinical record #9, start of care 8/31/12 evidenced a plan of care for the certification period 4/28/13 through 6/26/13 with orders for the home health aide to complete visits two times a week for the first week of the certification period and 3 times a week for the remaining eight weeks. The order stated,</p>		<p>important areas (infection control, ROM, and scope of practice for aides) on a permanent basis. The Performance Improvement Committee will audit ten (10) client records each month for a period of three (3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care, and that the home health aide assignments are complete and thorough. We will ensure that the aides are documenting care according to the patient's Home Health Aide assignment sheet, and that the assignment sheet appropriately reflects what is ordered on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Care and Home Health Aide Assignment sheet will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give</p>				

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	<p>"HHA [home health aide] to provide bathing assistance and safety while showering and perform light homemaking needs. Will visit 2 X week X 1 then 3 X week X 9 through the end of this certification period."</p> <p>A. The record evidenced documents titled "Home Health Aide Notes" documented by the individual completing the daily services and evidenced employees T, U, and V provided aide services between 4/126/13 through 6/12/13 and each employee documented the aide services provided. The aide visit notes reviewed failed to evidence documentation direct care home health aide services were provided as ordered on the plan of care.</p> <p>B. On June 24, 2013 at 12:45 PM, employee B indicated the patient required assistance to transfer in and out of the patient's regular bath tub. After reviewing the documentation of the aide visits, employee B indicated when asked, the aides were to provide direct care and assistance with bathing and transferring in and out of the tub.</p> <p>4. The undated policy titled "Home Health Aide Plan of Care C 760" stated, "A complete and appropriate care plan, identifying duties to be performed by the</p>		oversight to this plan of correction to ensure no further deficiencies in this area occur.	

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	home health aide, shall be developed by a registered nurse or therapist. All home health aide staff will follow the identified plan. ... The personal care plan shall be developed in plan, non technical terms and identify the duties to be performed such as, not limited to; a. Personal care. b. Ambulation and exercise. ... d. assistance with medications that are ordinarily self administered."			

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G000229	<p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 1 of 9 (# 8) active records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record # 8, start of care 4/29/13 and a plan of care for the certification period dated 4/29/13 through 6/27/13 and orders for the skilled nurse to provide skilled nurse services and stated, "SN 1W3: 1 every other week 6: 2 every third day 9 and orders for the home health aide two times a week for bathing and hygiene assistance. The record evidence the aide provided services in the patient's home on 5/31/13, 6/3/13, 6/7/13, and 6/14/13. <p>A. The record evidenced the patient was hospitalized 6/9/13 through 6/14/13.</p>	G000229	<p>CORRECTIVE ACTION TAKEN: This deficiency occurred due to the RN Case Manager not documenting that the patient was in the hospital during the time this supervisory visit was due. (Documentation for this patient was difficult due to frequent hospitalizations and poor communication with his son.) On 7/24/13 an in-service will be given with instructions and re-education to all RN's about the importance of following up with hospitalizations and patient status, especially in cases where the family does not communicate well with our agency. The nurses will also be re-educated on the importance of documenting when the patient is not available for a visit and a supervisory visit is due.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: A log will be maintained by the Director of Nurses recording any known hospitalizations for active patients in our agency. This log will be monitored and will include dates when the patient comes home and when the first SN visit will occur after the patient returns home. The Performance Improvement Committee will review this log on a monthly basis</p>	07/24/2013

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	<p>The record evidenced skilled nurse services were provided on 5/31/13 and 6/18/13. The record failed to evidence the skilled nurse completed a supervisory visit of the aide on 6/18/13 a period of time more than 14 days.</p> <p>B. The schedule of aide visits provided to the surveyors on 6/19/13 evidence employee H was scheduled to provide services on 6/21/13.</p> <p>2. On June 25, 2013, at 3:45 PM, the administrator indicated the patient was admitted to the hospital on June 9, 2013 and discharged on 6/14/13 there were no further documents to evidence.</p>		<p>to ensure that all hospitalized patients have received a follow up SN visit and that the patient's chart reflects this accurately. If supervisory visits were due during the time of hospitalization, the PI Committee will ensure that the RN Case Manager documented that the patient was in the hospital and the visit was not possible at that time. The PI Committee will audit 10 client records each month for a period of 3 months to ensure that all Supervisory Visits were done on time or that there was a reason documented for the visit not being done. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close monitoring of the hospitalization log will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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G000236	<p>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 summary.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure the clinical record contained a discharge summary in 2 of 4 records reviewed. (#5 and #13)</p> <p>Findings include:</p> <p>1. Clinical record #5 evidenced plans of care with a start of care date as 1/8/13 with a certification period of 1/8/13 to 3/8/13 and certification period of 3/9/13 to 5/7/13.</p> <p>A. A document titled "Home Health Patient Discharge Sheet" states, "Start of Care Date 01/08/2013 Discharge Date [undated] ... Summary of Care or services Provided, including Progress Toward Goals Unable to Assess patient by the end of the certification period D/T physicians's appt scheduled on the same day as assessment. Patient will be</p>	G000236	<p>CORRECTIVE ACTION TAKEN: An in-service will be held on 7-24-13 to re-educate all the nurses on the importance of completing a discharge summary to include a summary of care or services provided, including progress toward goals, patient's physical/psychosocial status at discharge, and discharge instructions to patient, including continued symptom management needs. In addition, instructions will be given to the nurses during this in-service about discharging and re-admitting patients. We will discuss the necessity of completely closing out a patient's chart and opening a completely new chart with new admission paperwork. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all discharged patients starting 7-24-13 by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight</p>	07/24/2013			

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	<p>re-admitted at next visit."</p> <p>B. On 6/24/13 at 2:20 PM, employee A (administrator) indicated patient had been discharged on 5/7/13 and the document was the discharge summary for this patient.</p> <p>2. Clinical record #13 evidenced a plan of care with a start of care date as 11/26/12 with a certification period of 11/26/12 to 1/24/13.</p> <p>A. The record contained a document titled "Home Health Patient Discharge Sheet" with a discharge date of 12/11/12, which failed to evidence documentation of a summary of care or services provided, including progress toward goals, patient's physical/psychosocial status at discharge, and discharge instructions to patient, including continued symptom management needs.</p> <p>B. On 6/24/13 at 2:15 PM, employee A indicated patient had been discharged on 12/11/12 and the document was the discharge summary for this patient.</p> <p>3. The undated policy titled "Client Discharge Process C-500" states, "Special Instructions Discharge Procedure ... 14. Servant's Heart Home Health Services staff will complete a discharge summary</p>		<p>to the audits. Charts will be monitored for complete discharge summaries. This audit will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of discharged charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>				

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	that includes the following information: A. client status at the time of admission to the agency b. Statement of client needs, interventions and outcomes of care c. Status at discharge/last visit/current medications, therapies, and continuing care needs d. Name of person or organization assuming responsibility for care e. instructions and referrals given to the client/family/caregiver f. Reason for discharge and date of discharge."			

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G000324	<p>484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the transmission of OASIS data was performed for all assessments completed in 1 of 4 patients requiring OASIS data collection and transmission. (#6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #6 had a start of care 1/30/13 and discharge date of 3/30/13. The record contained a document completed by employee A dated 3/30/13 titled "Outcome and Assessment Information Set". <p>On 6/24/13 at 3:39 PM, employee A indicated the document was never transmitted to the state agency as required.</p> <ol style="list-style-type: none"> 2. The undated agency policy titled "Encoding and reporting Oasis Data" states, "Policy when application has been made and approved for medicare payments, the agency will electronically report all OASIS data collected in 	G000324	<p>CORRECTIVE ACTION TAKEN: The OASIS related to this deficiency was transmitted on 7-19-13. CORRECTIVE ACTION TAKEN: A log of all OASIS patients will be developed by 7-24-13 and maintained by the Administrator. This log will verify that each OASIS has been completed in a timely manner, and that all necessary OASIS have been submitted, including Admissions, Re-certifications, and Discharge OASIS. RN Case Managers and/or Therapists will submit every OASIS within 5 days of completion of the assessment to the Administrator for transmission. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: This log will be monitored by the Administrator on a weekly basis as a new weekly task from this point forward to ensure that all necessary OASIS transmissions have been accomplished. The verification notice for each transmission will be maintained in a notebook to confirm the transmissions. PERSON RESPONSIBLE FOR THIS PLAN: The Administrator and/or designee will be responsible for ensuring that no</p>	07/24/2013			

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	accordance with federal regulations."		further deficiencies in this area occur.		

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G000340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. Based on clinical records and policy review and interview, the agency failed to ensure the comprehensive assessment was updated and revised within 48 hours of the patient's return from a hospital admission in 1 of 1 records reviewed of patients that were hospitalized. (# 8).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 8, start of care 4/29/13 and a plan of care for the certification period dated 4/29/13 through 6/27/13 and orders for the skilled nurse to provide skilled nurse services and stated, "SN 1W3: 1 every other week 6: 2 every third day 9. The record failed to evidence the comprehensive assessment was updated and revised within 48 hours upon return from a hospital admission. <p>On June 25, 2013, at 3:45 PM, the administrator indicated the patient was admitted to the hospital on June 9, 2013 and discharged on 6/14/13 and that the registered nurse had the original documentation on her person and it was</p>	G000340	<p>CORRECTIVE ACTION TAKEN: The nurse involved with this deficiency who had the original documentation on her person was re-educated on 7-8-13 on the importance of submitting all documentation within 7 days of completion of the visit according to our agency's policy. On 7/24/13 an in-service will be given with instructions and re-education for all RN's about the importance of completing a comprehensive assessment within 48 hours of any hospitalization and submitting documentation in a timely manner. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: A log will be maintained by the Director of Nurses recording any known hospitalizations for active patients in our agency. This log will be monitored and will include dates when the patient comes home and when the nurse performed the comprehensive assessment after the hospitalization. The Performance Improvement Committee will review this log on a monthly basis to ensure that all hospitalized patients have</p>	07/24/2013			

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	<p>not available in the clinical record or agency; there were no further documents to evidence.</p> <p>2. The undated agency policy titled "Client Reassessment/Update of Comprehensive Assessment" states, "The comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients ... Reassessments must be done at least: 1 ... 2 ... 3. Within 48 hours of (or knowledge of) discharge or transfer."</p>		<p>received a comprehensive assessment within 48 hours, and that the patient's chart reflects this accurately. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close monitoring of the hospitalization log will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review, policy review, and interview, the agency failed to ensure a comprehensive assessment was updated and revised (including the administration of the OASIS) at discharge in 1 of 4 discharged patient's records with the potential to affect all the agency's patients. (#7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #7 had a start of care date as 1/7/13 and a discharge date as 3/6/13. The record failed to evidence a comprehensive assessment to include Oasis items was completed at discharge. On 6/24/13 at 3:39 PM, employee A (administrator) indicated there was no comprehensive assessment at discharge for this patient. 2. The undated agency policy titled "Client Reassessment/Update of Comprehensive Assessment" states, "The comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. 	G000341	<p>CORRECTIVE ACTION TAKEN: The OASIS related to this deficiency was transmitted on 7-17-13. A log of all OASIS patients will be developed by 7-24-13 and maintained by the Administrator. This log will verify that each OASIS has been completed in a timely manner, and that all necessary OASIS have been submitted, including Admissions, Re-certifications, and Discharge OASIS. RN Case Managers and/or Therapists will submit every OASIS within 5 days of completion of the assessment to the Administrator for transmission. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: The OASIS log will be monitored by the Administrator on a weekly basis as a new weekly task from this point forward to ensure that all necessary OASIS transmissions have been accomplished. The verification notice for each transmission will be maintained in a notebook to confirm the transmissions. Monthly chart audits will be done on all discharged patients starting 7-24-13 by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits.</p>	07/24/2013
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	Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients ... Reassessments must be done at least: 1 ... 2 ... 3. Within 48 hours of (or knowledge of) discharge or transfer."		Charts will be monitored for complete discharge summaries and OASIS assessments. This audit will continue monthly for 3 months(through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of discharged charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

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N000000	<p>This visit was for a state home health agency re-licensure survey.</p> <p>Survey Dates: June 19, 20, 21, 24, and 25, 2013.</p> <p>Facility #: 011301</p> <p>Medicaid Vendor # 200852690</p> <p>Surveyor: Tonya Tucker, RN, PHNS Team Leader Bridget Boston, RN PHNS</p> <p>QA: Linda Dubak, R.N. July 10/2013</p>	N000000	<p>This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.</p>		

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N000478	<p>410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following:</p> <p>(1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.</p> <p>Based on document review and interview, the agency failed to ensure a written contract between personnel under contract and the home health agency specified the manner in which services will be controlled and coordinated by the primary home health agency in 1 of 1 contracts reviewed with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. A contract dated 10/29/2012 titled "Written Agreement for Home Care Contract Services" failed to evidence the</p>	N000478	<p>CORRECTIVE ACTION TAKEN: An addendum to the contract with Trinity Healthcare, Inc. (the contracting agency with Servant's Heart Home Health Services, Inc.) was written to state that the contracted staff will fax their visit notes to the Servant's Heart's office and mail the original documents within 7 days. This addendum was faxed to Trinity Healthcare, Inc. and signed by their appropriate manager as well as by Servant's Heart Home Health Services, Inc. administrator's signature to confirm this written agreement.</p> <p>PLAN TO PREVENT FUTURE DEFICIENCIES IN THIS AREA:</p>	07/15/2013			

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	<p>manner in which services will be controlled and coordinated by the home health agency.</p> <p>2. On 6/25/13 at 11:49, employee B indicated this was a new process and was unaware of the timeframe for contracted services to submit to the agency documentation following visit.</p> <p>3. The undated agency policy titled "Contract Personnel D-460" states, "Special Instructions ... 2. Contract personnel or organizations shall execute a written agreement, including charges, with Servant's Heart Home Health Services outlining the rules governing professional services rendered by contracted personnel ... a. The written agreement, signed by both parties, shall minimally include, but not be limited to: ... Procedures for submitting clinical notes, scheduling of visits and conducting periodic patient evaluation."</p> <p>4. On 6/25/13 at 12:20 PM, employee A indicated the home health agency and the contracted agency have a verbal agreement after therapy visits have been made, the contracted agency will fax the visit notes to the office and mail the documents to the agency within 7 days.</p>		<p>Going forward, all contracts will be reviewed to ensure that the written agreement between the contracted personnel and Servant's Heart Services specifies <u>in writing</u> the manner in which services will be controlled and coordinated and not be based only on a verbal understanding. PERSON RESPONSIBLE FOR THIS CORRECTION: The Administrator and/or Assistant Administrator</p>				

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N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure patients were informed of the Patient Rights found at 410 IAC 17-12-3 prior to the beginning of care for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The</p>	N000494	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being</p>	07/24/2013

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	<p>record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area</p>	

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N000496	<p>410 IAC 17-12-3(b) 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: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law. Based on clinical record review and interview, the agency failed to inform patients of the right that their family or legal representative could exercise the patient's rights as permitted by law for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission 	N000496	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists</p>	07/24/2013			

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	requirements.		of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.		

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N000500	<p>410 IAC 17-12-3(b)(2)(B) 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: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on clinical record review and interview, the agency failed to inform patients of the right to voice grievances regarding treatment or care that is or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The</p>	N000500	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done</p>	07/24/2013			

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	<p>record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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N000502	<p>410 IAC 17-12-3(b)(2)(C) 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: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on clinical record review and interview, the agency failed to ensure the patient had been notified of the right to place a complaint with the department regarding treatment or care furnished by the home health agency and was given the toll free number of the Home Health Complaint Hotline for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	N000502	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight</p>	07/24/2013	

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	2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.		to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

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N000504	<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 review and interview, the agency failed to ensure the patient was advised in advance of care of the disciplines that would furnish care and the frequency of visits and services proposed to be provided for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated</p>	N000504	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding the disciplines that would furnish care and the frequency of visits and services proposed. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE</p>	07/24/2013			

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	<p>4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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N000505	<p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on clinical record review and interview, the agency failed to ensure the patient was informed about the care to be furnished and of any changes in the care to be furnished for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents</p>	N000505	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding any changes in the disciplines that would furnish care and the frequency of visits and services proposed. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is</p>	07/24/2013	

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	<p>from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2013
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			in this area occur.	

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N000506	<p>410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on interview and clinical record review, the agency failed to ensure patients were advised of their right to be notified of any changes in the plan of care including a reasonable discharge notice for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	N000506	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding Patient's Rights and Responsibilities, including the right to be notified of any changes in their Plan of Care and to be given a reasonable notice of discharge. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day. PREVENTION OF FUTURE</p>	07/24/2013	

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	2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.		<p>DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that Patient Rights have been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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N000508	<p>410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was informed of the right to confidentiality of the medical records and the policies and procedures regarding disclosure of the clinical record for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated</p>	N000508	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding patient rights and confidentiality of records and our disclosure policies. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done</p>	07/24/2013			

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N000510	<p>410 IAC 17-12-3(b)(3) Patient Rights Rule 12 Sec. 3(b)(3) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (3) The patient or patient's legal representative has the right under Indiana law to access the patient's clinical records unless certain exceptions apply. The home health agency shall advise the patient or the patient's legal representative of its policies and procedures regarding the accessibility of clinical records.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient, or the patient's legal representative, was informed of the right to access the patient's records and of the agency's policies and procedures regarding the accessibility of clinical records for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents</p>	N000510	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding the patient's right to access patient records and our policies and procedures regarding their accessibility to records. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE</p>	07/24/2013			

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	<p>from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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N000512	<p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse. (B) Treated with dignity. Based on clinical record review and interview, the agency failed to ensure the patient was advised of their right to be free from verbal, physical, and psychological abuse and to be treated with dignity for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	N000512	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding patient rights. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance</p>	07/24/2013			

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N000514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was informed that the agency must investigate complaints and must document both the existence and the resolution of the complaint for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The</p>	N000514	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding investigation of complaints and the resolution of complaints. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p>	07/24/2013			

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	<p>record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p> <p>2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.</p>		<p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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N000516	<p>410 IAC 17-12-3(d) Patient Rights Rule 12 Sec. 3(d) (d) The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency as defined in 42 CFR § 420.201, 42 CFR § 420.202, and 42 CFR § 420.206, in effect on July 1, 2005.</p> <p>Based on clinical record review and interview, the agency failed to ensure patients were informed of the right to receive, if requested, a disclosure of the agency ownership for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	N000516	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding patient rights. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement Committee with the Administrator,</p>	07/24/2013			

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	2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.		DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.		

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N000518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was informed, prior to care, of the Indiana Advance Directives upon admission to the home health agency for 1 of 1 record reviewed which was admitted for skilled services at the branch location after the date of the last survey, March 26, 2013, with the potential to affect all patients of the agency. (1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record contained admission documents from a previous admission and dated 4/25/12 and unsigned consents dated 4/17/13.</p>	N000518	<p>CORRECTIVE ACTION TAKEN: This deficiency was a result of a patient being discharged and then immediately re-admitted due to skilled services being added to her Plan of Care. The RN who did this admission was re-educated on 6-26-13 concerning the importance of obtaining all new patient signatures to confirm the receipt of the admission packet, which includes the information regarding the Indiana Advance Directives. A staff meeting for all nurses will be held on 7-24-13 to re-educate them regarding the importance of completely closing out a discharged patient's chart and then starting an entirely new chart (including admission paperwork with signatures) for the patient, even if he/she is being re-admitted the same day.</p> <p>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all new admissions by the Performance Improvement</p>	07/24/2013	

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	2. On June 25, 2013 at 5:30 PM, the administrator indicated employee S required reeducation regarding admission requirements.		Committee with the Administrator, DON, and ADON giving oversight to the audits. (The Performance Improvement Committee consists of all staff nurses and office management personnel.) Charts will be monitored for patient signatures to confirm that the Admission packet has been received by every new admission patient. The first audit will be done on 7-24-13 and will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of admissions will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.		

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review, observation and interview, the agency failed to ensure the physician ordered plan of care included the specific interventions to be provided by the individuals providing aide services on behalf of the agency for 1 (# 1) of 9 records reviewed of current patients that received aide services and failed to ensure skilled services were provided as ordered 1 of 7 (# 10) current records with orders for a skilled nurse, creating the potential to affect all of the agency's current patients that received skilled nurse services.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 4/17/13 evidenced the patient was admitted for services with diagnosis of multiple sclerosis, onset in 2005 and bed confinement since 3/31/11. The comprehensive assessment dated 4/17/13 evidenced the patient was bed bound and had contracture's of the hands bilaterally. The plan of care, established by the physician for the certification periods</p>	N000522	<p>CORRECTIVE ACTION TAKEN: The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of updating the Plan of Care and obtaining a signed order by the physician to document when any visit is cancelled. All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. Instructions will be given to RN's to ensure that all home health aide assignment sheets accurately reflect a complete description of the aide's services, and that those services are noted on the Plan of Care as well. The aide involved with this deficiency was re-educated by the RN Case Manager on 7/16/13 regarding the following issues: 1. Following acceptable standards of care and Servant's Heart Services' policies regarding hand washing and changing gloves due to cross contamination issues while providing personal care for patients. 2. The scope of practice for aides when providing medication reminders, and how to accomplish this by involving the</p>	08/01/2013			

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	<p>dated 4/17/13 through 6/15/13 and 6/16/13 through 8/14/13 stated, "HHA 5 week 9 [five times a week for 9 weeks] ... to assist with all bathing, hygiene needs, grooming, repositioning Q2HRS [every 2 hours] as tolerated by patient, ... meal prep and feeding, range of motion exercises and medication reminders X [times] 60 days."</p> <p>A. The record evidenced a document titled "Servant's Heart Home Health Services Home Health Aide Assignment Sheet" dated 10/19/12, 12/18/12, 2/14/13, 4/16/13, and 6/11/13. The aide assignment evidenced directions to assist the patient with medication at 9 AM, 5 PM, and at bedtime. The assignment failed to evidence specifically how the aide was to assist the patient with medications. The directions failed to direct the aide to remove one 400 milligram neurontin capsule and to administer to the patient and failed to direct the aides to reposition the patient every 2 hours as ordered on the plan of care.</p> <p>B. The record evidenced document titled "Home Health Aide Notes" documented by the individual completing the daily services and evidenced employees F, H, I, K, L, and M provided aide services between 4/17/13 through 6/19/13 and</p>		<p>family or nurse with medication setup. She was instructed to never remove a medication from a bottle for a patient, and the importance of having the medications set up by the family and/or nurse prior to providing assistance to the patient. 3. She was given instruction regarding Range of Motion techniques, and observed providing appropriate ROM for the patient on this same date. 4. The importance of following and documenting care according to the home health aide assignment sheet for every patient. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All home health aides will be given written in-services on the following topics: 1. Infection control/hand washing and cross contamination 2. Appropriate scope of service for home health aides, including medication reminders 3. Range of Motion techniques 4. Performing and documenting care according to the home health aide assignment sheet for every patient. These in-services will be required to be completed by 8-1-13 and turned in to the Administrator. Any aide who does not achieve correct answers at 85% or higher will be given special one on one instruction and re-take the tests until 85% of the correct answers area accomplished. RN Case Managers will incorporate these same 4 topics as noted above with every supervisory visit for the</p>				

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	<p>documented by the individual completing the aide services. The aide visit notes reviewed failed to evidence documentation that the aide provided the change of position and repositioning every two hours as ordered or why the task was not completed and documented medication reminders were performed daily.</p> <p>C. Employee F provided aide services on June 11, 13, and 14, 2013. The visit notes failed to evidence range of motion was completed and why the task was not completed.</p> <p>D. Employee L provided aide services on June 8, 2013 and failed to evidence range of motion was completed and why the task was not completed.</p> <p>2. On June 19, 2013 at 4 pm, Employee A indicated patient #1 had no independent mobility and not able to move their little finger.</p> <p>3. During a home visit on June 20, 2013 at 9:10 AM, observed patient 1 without the ability to move independently and was dependent on employee L for all bed mobility and movement. Employee L and the patient indicated the aides that provide services to the patient, retrieve the patient's medications from a pre-set</p>		<p>next 12 months. (The Supervisory Visit form will be updated by 7-19-13 to include these issues.) In addition to the above interventions, every RN Case Manager will be assigned a team of aides (approximately 5 aides to each RN), and each aide will be required to: 1. perform ROM 2.demonstrate appropriate hand washing techniques 3. provide documentation regarding the care provided according to the written home health aide assignment sheet for every patient 4. demonstrate appropriate medication reminders as part of a regular skill checkoff. Other skills will also be observed (such as bathing, transferring,etc.) during these check offs as well to ensure the aides are providing high quality care for their patients. These skill check offs will be done with each aide once every quarter (or 4 times per year) for a period of 1 year,and written reports will be submitted to the Administrator for each aide. Any aide who is not able to follow and/or understand these policies or demonstrate appropriate skills after being instructed will be reported to the Administrator by the RN Case Manager for possible termination of employment. If no further deficiencies are noted in these areas, the Supervisory visits will continue to highlight these three important areas (infection control, ROM, and scope of practice for</p>				

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	<p>medication container twice a day, they place the medications in a small container and then place the container to the patients lips, the patient allows the employees to place the medications in his / her mouth and then the patient is given fluids by straw to assist with swallowing. The employee indicated daily at 5 PM, the aide on duty was to retrieve a 400 milligram neurontin capsule from a prescription bottle and administer this medication following the same procedure. Patient #1 confirmed that the staff place medication in his / her mouth and when asked, the patient indicated to not know what the medication administered at 5 PM was to treat. When asked, the patient indicated the aide on duty routinely give medications after they arrive in the morning around 9 AM, at 5 PM, and just before they leave in the evening, between 9 - 10 PM. The patient indicated if the aides leave before 9 PM, then a family member administer the night time medications. The patient indicated employee L administered the oral medications on the morning of 6/20/13 prior to the arrival of the surveyor. The employee indicated the patient requires feeding and was not capable of using finger to place anything in the mouth.</p> <p>4. Clinical record #10, start of care (SOC) 11/21/11, included a plan of care</p>		<p>aides) on a permanent basis. The Performance Improvement Committee will audit ten (10) client records each month for a period of three (3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Cares will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>				

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	<p>for the certification period 3/14/13 through 5/13/13 with orders for skilled nurse visits once a week for 3 weeks to preset the patient's medications. The record evidenced the skilled nurse conducted a nurse visit and assisted the patient's family member to prepare the patients medications on 3/13/13 and then returned on 3/21/13. The record failed to evidence the skilled nurse visits were made as ordered on the plan of care or a physician order to discontinue the previous skilled nurse visit order.</p> <p>On 6/19/13 at 3 PM the administrator indicated the skilled nurse visits were not made as ordered on the plan of care dated 3/14/13.</p> <p>5. The undated policy titled "Care Plans C - 660" stated, "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals. Following the initial assessment, a care plan shall be developed with the client and / or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care. ... The care plan shall include, but not be limited to: ... A</p>			

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	<p>list of specific interventions with plans for implementation</p> <p>6. The undated policy titled "Plan of Care / Doctor's Orders C - 580" stated, "Verbal / telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>7. The undated policy titled "Physician's Orders C - 635" stated, "All medications, treatment and services provided to clients must be ordered by a physician. Orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatment, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... Purpose - To document verification that orders for services have been obtained from the physician."</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse (RN) had provided treatments as ordered by the physician in 1 (# 10) of 8 current clinical records reviewed with orders for skilled nurse services with the potential to affect all current patients.</p> <p>The findings include:</p> <p>1. Clinical record #10, start of care 11/21/11, included a plan of care for the certification period 3/14/13 through 5/13/13 with orders for skilled nurse visits once a week for 3 weeks to preset the patient's medications. The record evidenced the skilled nurse conducted a nurse visit and assisted the patient's family member to prepare the patients medications on 3/13/13 and then returned on 3/21/13. The record failed to evidence the skilled nurse visits were made as ordered on the plan of care or a physician order to discontinue the previous skilled nurse visit order.</p> <p>On 6/19/13 at 4:30 PM the administrator</p>	N000537	<p>CORRECTIVE ACTION TAKEN: The RN Case Manager involved with this deficiency was re-educated on 7-8-13 about the importance of updating the Plan of Care and obtaining a signed order by the physician to document when a visit is cancelled. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All nursing staff will attend an in-service on 7-24-13 and be re-educated by the RN Administrator on the importance of providing services as ordered by the physician on the Plan of Care. The Performance Improvement Committee will audit ten (10) client records each month for a period of three(3) months to ensure that all visits, frequencies, and durations for each discipline are correctly documented on the Plan of Care. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the Plan of Care will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative</p>	07/24/2013
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	<p>indicated the skilled nurse visits were not made as ordered on the plan of care dated 3/14/13 and there was not an order to discontinue the skilled nurse visits.</p> <p>2. The undated policy titled "Plan of Care / Doctor's Orders C - 580" stated, "Verbal / telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>3. The undated policy titled "Physician's Orders C - 635" stated, "All medications, treatment and services provided to clients must be ordered by a physician. Orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatment, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... Purpose - To document verification that orders for services have been obtained from the physician."</p>		<p>trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers(the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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N000544	<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, agency policy review, and interview, the agency failed to ensure the registered nurse prepared clinical notes in 1 of 9 active patients records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 start of care date 5/3/13, contained a plan of care for certification period 5/3/13 to 7/1/13 which states, "21. SN: 1Month2:9 as needed 9: skilled nurse observation and assessment of cardiovascular and respiratory status, SN to assess vital signs including SPO2 and all body systems, medication compliance, monitor for edema, weight gain and signs and symptoms of complications. SN to instruct in disease progresses, medication regimen and compliance, falls precautions, bleeding precautions, and signs and symptoms to report. SN to set up medication planner every 4 weeks. SN to obtain labs as ordered by physician.</p>	N000544	<p>CORRECTIVE ACTION TAKEN: The RN involved with this deficiency was re-educated on 6-25-13 by the Administrator on the importance of documenting lab results and all other pertinent patient information in the patient's chart. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: All nursing staff will attend an in-service on 7-24-13 and be re-educated by the Administrator on the importance of documenting lab results and all other pertinent patient information in the patient's chart. The form used for Skilled Nursing visits will be revised by 7-24-13 to include specific areas to document when labs are drawn, what lab was ordered, and the results of the lab in order to make it easier to document these findings. This new form will be distributed to the RN's at the in-service scheduled on 7-24-13. A log for all patient lab draws will be maintained by the Director of Nurses and monitored by the Administrator. The Performance Improvement Committee will audit all charts listed on this log each month for a period of three (3) months to ensure they are documented in</p>	07/24/2013

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	<p>SN 1 visit per week PRN changes in medications that require a change in medication box before next scheduled visit for change in patients condition. ...</p> <p>22A. the patient's INR Lab value will be within normal limits per physician assessment and patient's compliance with meds/diet X 60 days."</p> <p>A. A document completed by employee B (Nursing Supervisor) dated 5/3/13 titled "Nursing admission Assessment Form" states, "Hx of past illnesses/hospitalizations/past surgeries: Hx afib, HTN, arthritis, long term use coumadin, next lab draw 6/4/13."</p> <p>B. A document completed by employee B dated 6/4/13 titled "Nursing Assessment Form" states, "SKILLED/INTERVENTIONS/TEACHING: Medication planner (4 weeks) set up completed. reminded pt due for PT/INR-prefers to have done @ VA; will go tomorrow.</p> <p>C. The record failed to evidence documentation of lab work performed or results/values reported to the agency.</p> <p>2. On 6/24/13 at 3:30 PM, employee B indicated receiving a call with the patients results as within normal limits but indicated no documentation was made of</p>		<p>the patient's file along with the lab results. The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of the nurse's documentation will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.</p> <p>PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>		

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	<p>the call or the results in the patient record.</p> <p>3. The undated agency policy titled "Clinical Records/Medical Record Retention C-870" states, "Special Instructions Clinical Record: ... 5. Documentation shall establish that effective interchange, reporting, and coordination of client care does occur."</p>			

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure the clinical record contained a discharge summary in 2 of 4 closed records reviewed. (#5 and #13)</p> <p>Findings include:</p> <p>1. Clinical record #5 evidenced plans of care with a start of care date as 1/8/13 with a certification period of 1/8/13 to 3/8/13 and certification period of 3/9/13 to 5/7/13.</p> <p>A. A document titled "Home Health Patient Discharge Sheet" states, "Start of</p>	N000608	<p>CORRECTIVE ACTION TAKEN: An in-service will be held on 7-24-13 to re-educate all the nurses on the importance of completing a discharge summary to include a summary of care or services provided, including progress toward goals, patient's physical/psychosocial status at discharge, and discharge instructions to patient, including continued symptom management needs. In addition, instructions will be given to the nurses during this in-service about discharging and re-admitting patients. We will discuss the necessity of completely closing out a patient's chart and opening a completely new chart with new admission</p>	07/24/2013

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	<p>Care Date 01/08/2013 Discharge Date [undated] ... Summary of Care or services Provided, including Progress Toward Goals Unable to Assess patient by the end of the certification period D/T physicians's appt scheduled on the same day as assessment. Patient will be re-admitted at next visit."</p> <p>B. On 6/24/13 at 2:20 PM, employee A (administrator) indicated patient had been discharged on 5/7/13 and the document was the discharge summary for this patient.</p> <p>2. Clinical record #13 evidenced a plan of care with a start of care date as 11/26/12 with a certification period of 11/26/12 to 1/24/13.</p> <p>A. The record contained a document titled "Home Health Patient Discharge Sheet" with a discharge date of 12/11/12, which failed to evidence documentation of a summary of care or services provided, including progress toward goals, patient's physical/psychosocial status at discharge, and discharge instructions to patient, including continued symptom management needs.</p> <p>B. On 6/24/13 at 2:15 PM, employee A indicated patient had been discharged on 12/11/12 and the document was the</p>		<p>paperwork. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all discharged patients starting 7-24-13 by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for complete discharge summaries. This audit will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of discharged charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.</p>	

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	<p>discharge summary for this patient.</p> <p>3. The undated policy titled "Client Discharge Process C-500" states, "Special Instructions Discharge Procedure ... 14. Servant's Heart Home Health Services staff will complete a discharge summary that includes the following information:</p> <p>A. client status at the time of admission to the agency b. Statement of client needs, interventions and outcomes of care c. Status at discharge/last visit/current medications, therapies, and continuing care needs d. Name of person or organization assuming responsibility for care e. instructions and referrals given to the client/family/caregiver f. Reason for discharge and date of discharge."</p>			

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N000614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>2. Clinical record # 1 SOC 4/17/13, contained consents dated 4/25/12 and unsigned consents dated 4/17/13, one aide assignment document dated 10/19/12, and updated 12/18/12, 2/14/13, 4/16/13, and 6/19/13, and plans of care dated 4/17/13 through 6/15/13.</p> <p>On 6/20/13 at 11:30 AM, employee A indicated the patient received only aide services while the primary caregiver worked and also respite services and then the patient was admitted on 4/17/13 for skilled nursing services with a new start of care date of 4/17/13.</p>	N000614	<p>CORRECTIVE ACTION TAKEN: An in-service will be held on 7-24-13 to re-educate all the nurses on the importance of completing a discharge summary to include a summary of care or services provided, including progress toward goals, patient's physical/psychosocial status at discharge, and discharge instructions to patient, including continued symptom management needs. In addition, instructions will be given to the nurses during this in-service about discharging and re-admitting patients. We will discuss the necessity of completely closing out a patient's chart and opening a completely new chart with new admission paperwork. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will</p>	07/24/2013			

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	Based on clinical record review and interview, the agency failed to ensure closed files were kept separate from current service files if the patient is readmitted to service in 2 of 9 active patient records reviewed with the		be done on all discharged patients starting 7-24-13 by the Performance Improvement Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for complete discharge summaries. This audit will continue monthly for 3 months (through 10-24-13). The PI Committee will evaluate the effectiveness of this plan based on trends identified. The PI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of discharged charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Director of Nurses, and Assistant Director of Nurses) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.		

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	<p>potential to affect all the agency's patients. (# 1 and 5)</p> <p>Findings include:</p> <p>1. Clinical record #5 start of care (SOC) 5/13/13, contained a plan of care with a SOC as 11/26/12 with a certification period of 11/26/12 to 1/24/13, a plan of care with a SOC as 1/8/13 with a certification period of 1/8/13 to 3/8/13 and a certification period of 3/9/13 to 5/7/13, patient consents dated 1/8/13, nursing admission assessment form dated 1/8/13, and a medication profile dated 1/8/13 and updated 3/6/13.</p> <p>A. On 6/24/13 at 2:10 PM, employee B indicated patient had been admitted to the agency on 11/26/12 and discharged on 12/11/12.</p> <p>B. On 6/24/13 at 2:20 PM, employee A (administrator) indicated patient had been readmitted on 1/8/13, discharged on 5/7/13, and readmitted on 5/13/13. Employee A indicated the clinical record should contain documentation of the patient's active certification period and documentation of past admissions should be contained in a closed chart.</p>			