

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2015
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NAME OF PROVIDER OR SUPPLIER  SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
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G 000  Bldg. 00	<p>This was a federal home health complaint investigation survey. This was an extended survey.</p> <p>Complaint #: IN00160903 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Facility #: 12928</p> <p>Survey Dates: February 18, 19, 20, and 23, 2015</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Scott's Home Healthcare LLC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 23, 2015, through February 23, 2017, for being found to be out of compliance with the Condition of Participation 42 CFR 484.48: Clinical Records as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 24, 2015</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G 108  Bldg. 00	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>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, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 3 of 7 active patient records reviewed creating the potential to affect all 107 of the agency's patients. (#2, #5, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p>	G 108	<p>Appropriate staff to be in serviced on the following: Missed Visit Note revised to state date and time patient was notified of inability to fill visit, all applicable staff notified to attempt to fill visit, date and time MD was notified of missed visit, person assuming care for patient, and RN signature. Scheduling employees to complete Missed Visit Note immediately upon cancellation by patient or home health agency and contact patient to make alternate plans for coverage. Administrator to ensure compliance is maintained by coordinating daily huddle, reviewing missed visits that occurred per on call and communication form notice, and verifying scheduling has completed task appropriately. RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the</p>	03/30/2015

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	<p>A. The record evidenced a document dated 1/24/15, signed by employee BB (home health aide), titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>B. The record evidenced a document dated 1/25/15, signed by employee BB, titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>C. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated the home health aide is supposed to come at 9 AM every day for 1 hour. The patient indicated a few times the aide came at 10 AM instead of 9 AM and indicated not being notified of the change in arrival time. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p>		<p>MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made.</p>	

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	<p>D. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank] ... ."</p> <p>B. The record contained a document titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care'</p>			

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	<p>... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse] ... ." The record evidenced the next skilled nursing visit was conducted on 2/13/15 and failed to evidence the patient was notified of the change in the plan of care.</p> <p>1.) The record evidenced a physicians order from the wound center stating, "Date: 2/09/15 Time: 1500 ... Orders Note: Only those items checked will be carried out. ... DIAGNOSIS: Number/Location Wound #(s): '#3' Location: '[left] axilla' Dressing Orders Aquacel Ag/Gauze/Medipore ... Cleanse Wound(s) with: Normal Saline ... Physician or Physician Extender Signature: [physician at wound center] Date: 2/9/15 Time: 1525 ... ."</p> <p>2.) A document titled "Clinical Note" states, "2-9-15 St. [Saint] Joseph Wound Center sent orders for pt [patient] to have daily dressing changes to wound to [left] axilla. Case manager notified. MD aware. Will begin dressing change</p>			

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	<p>2/10/15 after pt receives wound care supplies. [employee K-registered nurse]." The document states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]." The document states, "2-12-15 1145 A [AM] - St. Joseph Wound Center called et stated pts supplies are now delivered. Called pts PCP [primary care physician] et notified him that office had order for wound care daily. MD stated to start wound care 2/13/15. [employee K]."</p> <p>3.) On 2/19/15 at 3:50 PM, employee K (registered nurse) indicated receiving a call from patient #5 on 2/10/15 with concerns of the skilled nurse not visiting for wound care. The employee indicated contacting the wound center on 2/10/15 in regards to wound care supplies. The employee indicated he/she failed to make contact with the patient in regards to plan for treatment.</p> <p>3. Clinical record #10 contained a physician's plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home</p>			

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	<p>health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form</p>			

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G 121  Bldg. 00	<p>needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>4. The agency policy with an effective date of 7/20/15, a revised date of 8/20/12, and a reviewed date as 7/25/14 titled "PATIENT RIGHTS AND RESPONSIBILITIES" states, "PATIENT'S RIGHTS ... 5. You have the right to expect the agency to have the proper resources to render safe care of the frequency of visits proposed. 6. You have the right to be told in advance what disciplines will furnish care and the frequency of visits proposed. ... 8 You have the right to know in advance of any change in your plan of care before the change is made. ... ."</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and</p>			

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	<p>principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record review, agency policy review, observation and interview, the agency failed to ensure staff followed infection control practices for 1 of 5 home visit observations and failed to ensure the clinical record contained appropriately authenticated and dated clinical notes as required by agency policy in 1 of 10 clinical records reviewed creating the potential to affect all patients of the agency. (#4 and #5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit observation on 2/19/15 at 11 AM, employee J (licensed practical nurse), was observed providing wound care to patient #5. After donning clean gloves, employee J prepped a table with the wound care supplies, cleansed the wound with normal saline on a gauze pad and then placed the pad in a trash bag, applied Aquacel Ag wound pad inside the wound, covered with a sterile gauze pad, applied tape to secure, removed gloves and placed in trash bag, and then washed hands with soap and water.</li> </ol> <p>A. The agency policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION</p>	G 121	<p>Appropriate staff to be in serviced: All clinical staff will be required to attend an in service and skills check off regarding proper infection control procedures. All staff hired by the HHA will be required to perform a competency skills check off on proper infection control procedures. All clinical staff will be required to attend and complete a yearly in service including a skills check off to ensure proper infection control practices are being performed. HR staff to document and track in service and skills check off. Administrator to receive copy of completion as follow up. All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards and principles that apply to home health documentation . All documentation is to be properly authenticated by the staff member who completes the work <u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the</p>	03/30/2015	

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	<p>CONTROL" states, "POLICY: All home care staff will follow established infection control procedures. PURPOSE: To provide measures to prevent exposures to infectious diseases during the treatment of patients. PROCEDURE: Standard Precautions/Universal Precautions 1. Standard Precautions are routine barrier precautions that are utilized with all patients to protect employees from contact with blood and body fluids, secretions, excretions, non-intact skin, and mucous membranes. ... 4. Staff should was their hands before and after patient contact, upon removal of gloves, before and after invasive procedures, after handling soiled or contaminated materials, ... and as needed. 5. Medical gloves should be worn when: a) contact with blood or body fluids is likely; b) providing care to non-intact skin; c) handling or cleaning contaminated equipment ... 6. Gloves should be changed between patient contact and procedures. Hands should be washed thoroughly after removal of gloves. ... ."</p> <p>B. The agency policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION CONTROL-HAND WASHING" states, "POLICY: All health care workers shall wash their hands frequently and</p>		<p>checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar. 3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between the in and out time documented and confirming these were completed in accordance with the HHA careplan. 5. The hha should then request for the patient/or patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are</p>	

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	<p>appropriately. ... Health care workers shall wash hands: ... 4. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, ... "</p> <p>2. Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>A. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication</p>		<p>confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make any type of alteration on the home health aide notelf notes do not match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health</p>		

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	<p>Reminder [checked] ... <b>HOMEMAKING</b> ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>B. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the</p>		<p>aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and giving to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down <b>during a visit</b> and realizes it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on the HHA note completion policy and has instructed them that immediate termination would be the consequence of violating this policy. HR to track all attendance of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented</p>				

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	<p>aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>C. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly. ... "</p> <p>D. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and</p>		<p>minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

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G 158 Bldg. 00	<p>retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ... ."</p> <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. Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 4 of 7 active patients reviewed creating the potential to affect all 107 patients of the agency. (#2, #5, #6, and #10)  Findings include:</p>	G 158	All appropriate staff to be in serviced on the following: Daily huddles to be completed with each member of scheduling, case management, and HR every morning. At this time weekly schedules to be reviewed, indicating any unfilled visits, concerns, and missed visits that need addressed due to absences by home health aides. Daily	03/30/2015

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	<p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p> <p>B. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p>		<p>Huddle Form to be utilized to ensure these topics are addressed. Assistant to Administrator to collect all forms and compile summary for Administrator. Administrator to ensure resolution occurs on all unfilled visits or concerns covered in daily huddle by end of business day. Communication forms to be utilized by scheduling and completed on every phone call taken regarding home health aide or patient. Once concern is documented, RN to be notified immediately to inform of situation. RN to instruct on resolution if scheduling can complete. Patient to be called back and documentation completed on every concern or request. Once resolution is completed and RN has signed and documented, all completed forms to go to Administrator for review and filing. Communication Form to be filed in patient chart, last tab, to ensure continuity of care, and show communication between scheduling, nursing and patient. A policy has been established to address compliance with the agency responsibility to meet the needs of the patient once accepted into care. Patients will not be accepted for admission if the agency is not able to meet the needs of the patient upon initial assessment. The established policy is as follows: Policy: It is the policy of the company to</p>				

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	<p>C. On 2/23/15 at 12:55 PM, employee E indicated being unable to locate documentation related to the missed home health aide visits on 1/10 and 1/11/15.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank] ... ."</p> <p>3. Clinical record #6 contained a physicians plan of care for certification period 12/31/14 to 2/28/15 with orders to include home health aide services 3 hours per day, 7 days per week for 60 days.</p>		<p>maintain patient care consistency per M.D. orders. As part of this policy it must be acknowledged that there are two types of missed visits. One, being a patient cancellation and tow, being agency staff cancellation. PROCEDURE: 1) Patient cancellation: will be addressed if the patient cancellation causes non compliance with the physician's order. A missed visit form will be completed and given to the Administrator and CM Nurse. Administrator to log in Missed Visit Log for tracking. If the patient has more than two cancellations within the current certification period, the patient will be discharged according to policy. 2) Agency staff cancellation will be addressed by utilizing all other home health aide staff, on call home health aide, all available agency staff from the scheduling staff, up the organizational chart, to the Administrator in order to maintain compliance. Non compliance with this policy is unacceptable and scheduling staff will be terminated if policy is not maintained. On Call employees to call in and report to Administrator at end of each shift on any concerns that arose during shift. Typed report to be emailed to Administrator which will be distributed to all nursing and scheduling staff to be reviewed in daily huddle. Administrator to ensure</p>	

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	<p>The record failed to evidence home health aide services were conducted on 1/6/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record evidenced a document dated 1/14/15 by employee N (registered nurse) titled "MISSED VISIT FORM" stating, "Patient: [patient #6] Date/Time of Visit: '1-6-15 10 A -1 P' Type of Visit: 'HHA [home health aide]' ... Reason: Other [checked] 'HHA called off and couldn't fill hours' How were patient's needs met? [blank] ... ."</p> <p>4. Clinical record #10 contained a physicians plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p>		<p>compliance is maintained and proper documentation is completed. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>		

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	<p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>5. The agency policy with an effective date as 7/20/12 and a reviewed date of 7/25/14 titled "MISSED VISIT" states, "POLICY: It is the policy of the company to maintain patient care consistency per M.D. [medical doctor] orders. ... PROCEDURE: 1. A missed</p>			

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G 226 Bldg. 00	<p>visit occurs when the physician-ordered frequency of services is not maintained. ... 3. A missed visit constitutes a modification in the plan of care and the physician must be notified. .... "</p> <p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered. Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients. (#4)</p> <p>Findings include:</p> <p>1 . Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per</p>	G 226	<p>Appropriate staff to be in serviced on the following: All Home Health Aide Daily Notes will be completed in entirety by Home health Aide completing visit. Home Health Aide is required to mark appropriately boxes indicating patient care completed and sign document under Employee Signature. Patient or documented authorized signature is to sign under Patient Signature. In the case evidence is found to have missing information of any kind on Home Health Aide Daily note, Scheduler will contact Home Health Aide during current business day, who</p>	03/30/2015	

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	<p>day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>2. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOMEMAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>3. The record contained a document titled "Home Health Aide Daily Note"</p>		<p>will be required to come in to office and complete note. If patient signature is missing Home Health Aide will be required to retrieve note, deliver to patient for signature and date, and return to office within 24 hours of notification. Auditor employee to audit charts for note accuracy monthly. Disciplinary action including write up and counseling by HR employee to be properly enforced if Home Health Aide has a repeat offense. Administrator to be notified by Schedulers of any corrective action taken and upon completion through communication form. Mandatory In service to be completed by every Home health Aide on proper Home Health Aide Daily note completion. HR to track attendance of mandatory in service to ensure compliance. Administrator to ensure compliance is maintained by meeting with Auditor employee monthly to review any corrections made in order to educate staff on patterns that are seen. Policy created to provide specific scope of practices for Home Health Aides. Copy of this policy: <b>Scott's Home Healthcare LLC</b></p> <p><b>Job Title:</b> Home Health Aide <b>Effective:</b> 3-30-15 <b>No:</b> 606.00</p>		

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	<p>stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>4. On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the</p>		<p><b>Reviewed:</b> <b>Direct Report:</b> RN Case Manager <b>Revised:</b></p> <p><b>"Primary Purpose:</b> The primary purpose of your job position is to provide high quality home health aide services within the home health aide scope of practice to assigned patients in their place of residence with our established policies and procedures, and as may be directed by your RN supervisor.</p> <p><b>Performance Responsibilities According to Home Health Aide Scope of Practice:</b></p> <p>A. Patient Care</p> <p>1.Performs personal care activities contained in a written assignment by the Case Manager which includes: Personal hygiene, assisting with ambulation, oral care, skin care, hair care, cooking, feeding, dressing, shaving, vital signs and nail care.</p> <p>1.Assists with/Reminds of Medications – limited to opening and closing a medication container, returning a medication to the proper storage area and assisting in reordering medications from a pharmacy. Home Health aides are not to administer medications including applying prescription creams or powders but may assist</p>	

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	<p>document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly. ... ."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ... ."</p>		<p>patient as needed and as included on home health aide careplan.</p> <p>2. Follows a written plan of care, which includes realistic goals and interventions, which is prepared by the case manager.</p> <p>3. Performs assigned activities that are taught by an RN.</p> <p>4. Responds to patient needs in a timely manner.</p> <p>5. Provides care in a cost effective manner.</p> <p>6. Treats all patients with kindness and respect</p> <p>7. Completes housekeeping tasks as written and directed on the plan of care..."</p> <p>This policy states that Home Health Aides are not to give any medications to patients. Home Health Aides are allowed, if care plan states, to provide medication reminders to patient. No Home Health Aide will provide any topical application of prescription cream and will follow counseling/disciplinary procedure as needed for violation. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

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G 235  Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients (See G 236).</p> <p>The cumulative effect of this systemic problem resulted in the agency's inability to meet the requirements of the Condition of Participation 484.48 Clinical Record.</p>	G 235	<p>Appropriate staff to be in serviced on the following: All Home Health Aide Daily Notes will be completed in entirety by Home health Aide completing visit. Home Health Aide is required to mark appropriately boxes indicating patient care completed and sign document under Employee Signature. Patient or documented authorized signature is to sign under Patient Signature. In the case evidence is found to have missing information of any kind on Home Health Aide Daily note, Scheduler will contact Home Health Aide during current business day, who will be required to come in to office and complete note. If patient signature is missing Home Health Aide will be required to retrieve note, deliver to patient for signature and date, and return to office within 24 hours of notification. Auditor employee to audit charts for note accuracy monthly. Disciplinary action including write up and counseling by HR employee to be properly enforced if Home Health Aide has a repeat offense. Administrator to be notified by Schedulers of any corrective action taken and upon completion through communication form. Mandatory In service to be completed by every Home health Aide on proper Home Health Aide Daily</p>	03/30/2015

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G 236  Bldg. 00	<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, policy review, and interview, the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per</p>	G 236	<p>note completion. HR to track attendance of mandatory in service to ensure compliance. Administrator to ensure compliance is maintained by meeting with Auditor employee monthly to review any corrections made in order to educate staff on patterns that are seen.</p> <p>All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards and principles that apply to home health documentation. All documentation is to be properly authenticated by the staff member who completes the work</p>	03/30/2015

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	<p>day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>2. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOMEMAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>3. The record contained a document titled "Home Health Aide Daily Note"</p>		<p><u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar. 3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between the in and out time documented and confirming these were completed in accordance with the HHA careplan. 5. The hha should then request for the patient/or</p>	

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	<p>stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>4. On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the</p>		<p>patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make any type of alteration on the home health aide notelf notes do not</p>	

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	<p>document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly. ... ."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ... ."</p>		<p>match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and giving to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down <b>during a visit</b> and realizes it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on the HHA note completion policy and has instructed them that immediate termination would be the consequence of violating this policy. HR to track all attendance</p>		

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N 000  Bldg. 00	<p>This visit was for for a state home health relicensure survey.</p> <p>Survey Dates: February 18, 19, 20, and 23, 2015.</p> <p>Facility #: 12928</p> <p>Medicaid #: 201091400</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 24, 2015</p>	N 000	<p>of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

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N 504 Bldg. 00	<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, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 3 of 7 active patient records reviewed creating the potential to affect all 107 of the agency's patients. (#2, #5, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's</p>	N 504	<p>Missed Visit Note revised to state date and time patient was notified of inability to fill visit, all applicable staff notified to attempt to fill visit, date and time MD was notified of missed visit, person assuming care for patient, and RN signature. Scheduling employees to complete Missed Visit Note immediately upon cancellation by patient or home health agency and contact patient to make alternate plans for coverage. Administrator to ensure compliance is maintained by coordinating daily huddle, reviewing missed visits that occurred per on call and communication form notice, and verifying scheduling has completed task appropriately. On Call employees to call in and report to Administrator at end of each shift on any concerns that arose during shift. Typed report</p>	03/30/2015

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	<p>notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/24/15, signed by employee BB (home health aide), titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>B. The record evidenced a document dated 1/25/15, signed by employee BB, titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>C. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated the home health aide is supposed to come at 9 AM every day for 1 hour. The patient indicated a few times the aide came at 10 AM instead of 9 AM and indicated not being notified of the change in arrival time. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted</p>		<p>to be emailed to Administrator which will be distributed to all nursing and scheduling staff to be reviewed in daily huddle. Administrator to ensure compliance is maintained and proper documentation is completed. RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Home Health Agency to provide supplies for any wound care ordered by MD until supplies are delivered in order to provide continuity of care to patient. RN to notify Administrator of needs. Account set up at Moore's Home health store in order to allow RN to purchase supplies needed.</p>		

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	<p>back from the agency.</p> <p>D. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank] ... ."</p> <p>B. The record contained a document titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15'</p>			
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	<p>... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse] ... ." The record evidenced the next skilled nursing visit was conducted on 2/13/15 and failed to evidence the patient was notified of the change in the plan of care.</p> <p>1.) The record evidenced a physicians order from the wound center stating, "Date: 2/09/15 Time: 1500 ... Orders Note: Only those items checked will be carried out. ... DIAGNOSIS: Number/Location Wound #(s): '#3' Location: '[left] axilla' Dressing Orders Aquacel Ag/Gauze/Medipore ... Cleanse Wound(s) with: Normal Saline ... Physician or Physician Extender Signature: [physician at wound center] Date: 2/9/15 Time: 1525 ... ."</p> <p>2.) A document titled "Clinical Note" states, "2-9-15 St. [Saint] Joseph Wound Center sent orders for pt [patient] to have daily dressing changes to wound</p>			

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	<p>to [left] axilla. Case manager notified. MD aware. Will begin dressing change 2/10/15 after pt receives wound care supplies. [employee K-registered nurse]." The document states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]." The document states, "2-12-15 1145 A [AM] - St. Joseph Wound Center called et stated pts supplies are now delivered. Called pts PCP [primary care physician] et notified him that office had order for wound care daily. MD stated to start wound care 2/13/15. [employee K]."</p> <p>3.) On 2/19/15 at 3:50 PM, employee K (registered nurse) indicated receiving a call from patient #5 on 2/10/15 with concerns of the skilled nurse not visiting for wound care. The employee indicated contacting the wound center on 2/10/15 in regards to wound care supplies. The employee indicated he/she failed to make contact with the patient in regards to plan for treatment.</p> <p>3. Clinical record #10 contained a physician's plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours</p>			

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	<p>per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient</p>			

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N 522 Bldg. 00	<p>notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>4. The agency policy with an effective date of 7/20/15, a revised date of 8/20/12, and a reviewed date as 7/25/14 titled "PATIENT RIGHTS AND RESPONSIBILITIES" states, "PATIENT'S RIGHTS ... 5. You have the right to expect the agency to have the proper resources to render safe care of the frequency of visits proposed. 6. You have the right to be told in advance what disciplines will furnish care and the frequency of visits proposed. ... 8 You have the right to know in advance of any change in your plan of care before the change is made. ... ."</p> <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,</p>			

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	<p>dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 4 of 7 active patients reviewed creating the potential to affect all 107 patients of the agency. (#2, #5, #6, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the</p>	N 522	All appropriate staff to be in serviced on the following: Daily huddles to be completed with each member of scheduling, case management, and HR every morning. At this time weekly schedules to be reviewed, indicating any unfilled visits, concerns, and missed visits that need addressed due to absences by home health aides. Daily Huddle Form to be utilized to ensure these topics are addressed. Assistant to Administrator to collect all forms and compile summary for Administrator. Administrator to ensure resolution occurs on all unfilled visits or concerns covered in daily huddle by end of business day. A policy has been established to address compliance with the agency responsibility to meet the needs of the patient once accepted into care. Patients will not be accepted for admission if the agency is not able to meet the needs of the patient upon initial assessment. The established policy is as follows: Policy: It is the policy of the company to maintain patient care consistency per M.D. orders. As part of this policy it must be acknowledged that there are two types of missed visits. One, being a patient cancellation and tow, being agency staff cancellation. PROCEDURE: 1) Patient	03/30/2015			

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	<p>office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p> <p>B. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>C. On 2/23/15 at 12:55 PM, employee E indicated being unable to locate documentation related to the missed home health aide visits on 1/10 and 1/11/15.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member:</p>		<p>cancellation: will be addressed if the patient cancellation causes non compliance with the physician's order. A missed visit form will be completed and given to the Administrator and CM Nurse. Administrator to log in Missed Visit Log for tracking. If the patient has more than two cancellations within the current certification period, the patient will be discharged according to policy. 2) Agency staff cancellation will be addressed by utilizing all other home health aide staff, on call home health aide, all available agency staff from the scheduling staff, up the organizational chart, to the Administrator in order to maintain compliance. Non compliance with this policy is unacceptable and scheduling staff will be terminated if policy is not maintained. Communication forms to be utilized by scheduling and completed on every phone call taken regarding home health aide or patient. Once concern is documented, RN to be notified immediately to inform of situation. RN to instruct on resolution if scheduling can complete. Patient to be called back and documentation completed on every concern or request. Once resolution is completed and RN has signed and documented, all completed forms to go to Administrator for review and filing. Communication Form to be filed in patient chart,</p>		

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	<p>[Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank] ... ."</p> <p>3. Clinical record #6 contained a physicians plan of care for certification period 12/31/14 to 2/28/15 with orders to include home health aide services 3 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record evidenced a document dated 1/14/15 by employee N (registered nurse) titled "MISSED VISIT FORM" stating, "Patient: [patient #6] Date/Time of Visit: '1-6-15 10 A -1 P' Type of Visit: 'HHA [home health aide]' ... Reason: Other [checked] 'HHA called off and couldn't fill hours' How were patient's needs met? [blank] ... ."</p> <p>4. Clinical record #10 contained a physicians plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on</p>		last tab, to ensure continuity of care, and show communication between scheduling, nursing and patient.	

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	<p>1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank] ... ."</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how</p>				

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N 608 Bldg. 00	<p>the patient's needs were met and documentation of any attempts of replacement.</p> <p>5. The agency policy with an effective date as 7/20/12 and a reviewed date of 7/25/14 titled "MISSED VISIT" states, "POLICY: It is the policy of the company to maintain patient care consistency per M.D. [medical doctor] orders. ... PROCEDURE: 1. A missed visit occurs when the physician-ordered frequency of services is not maintained. ... 3. A missed visit constitutes a modification in the plan of care and the physician must be notified. ...."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and 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</p>			

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	<p>is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>2. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal</p>	N 608	<p>All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards and principles that apply to home health documentation. All documentation is to be properly authenticated by the staff member who completes the work <u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar.</p>	03/30/2015

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	<p>[checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOME MAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>3. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOME MAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E]</p>		<p>3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between the in and out time documented and confirming these were completed in accordance with the HHA careplan. 5. The hha should then request for the patient/or patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits</p>	

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	<p>Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>4. On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7.</p>		<p>are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make any type of alteration on the home health aide note If notes do not match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and giving to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down <b>during a visit</b> and realizes</p>	

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	<p>Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly. ... ."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ... ."</p>		<p>it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on the HHA note completion policy and has instructed them that immediate termination would be the consequence of violating this policy. HR to track all attendance of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from</p>	

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			recurring in the future.		