

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K082	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807
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G000000	<p>This was a federal Home Health Agency complaint investigation.</p> <p>Complaint #: IN00132043 - Unsubstantiated: Lack of sufficient information. Unrelated deficiencies are cited.</p> <p>Facility #: 012746</p> <p>Survey dates: August 13 and 14, 2013.</p> <p>Medicaid Vendor #: 201061990A</p> <p>Medical Records Reviewed: 3 Closed Records: 2 Active Records: 1</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 19, 2013</p>	G000000		

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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G000141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on employee file review, policy review, job description review, and interview, the agency failed to ensure it followed its own policy for a current driver's license upon hire for 1 of 4 employee files reviewed with the potential to affect all the agency's patients. (E)</p> <p>Findings include</p> <ol style="list-style-type: none"> The agency's job description titled "Home Health Aide" dated 4/2010 states, "Position Qualifications: ... Valid Driver's License." The agency's policy titled "Personnel Files" dated April 2010 states, "Personnel Files shall include the following: ... 4. Copy of valid driver's license." Review of employee file E, a Home Health Aide, date of hire 1/8/13, evidenced the employee's driver's license expired on 12/8/12. The file failed to evidence an updated or current copy of driver's license was obtained. 	G000141	<p>The HR Manager shall audit 100% of active personnel records by 09/06/2013 to ensure compliance with agency's policy which states upon hire, employee's will have a current /valid driver's license, a copy of the current/valid driver's license shall be kept in the employee's personal file.</p> <p>100% of all new hired employees HR files shall be audited monthly, by the HR Manager thereafter until 100% are within compliance, as evidence by a copy of current driver's</p>	09/06/2013			

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	4. On 8/14/13 at 10:50 AM, employee G indicated there was not an updated driver's license in file, but employee did not begin providing care to patients until 3/22/13 and the agency just received notice today that the license was renewed on 3/16/13 but as far as employee G knows, the HHA was not driving to work until then.		license in personnel file upon hire and onward. Personnel records shall be reviewed quarterly thereafter, by the HR Manager. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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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. Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the Plan of Care for 3 of 3 clinical records reviewed with the potential to affect all the agency's patients. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 8/1/12, contained a Home Health Certification and Plan of Care for the certification period 7/22-9/19/13 with orders for Skilled Nurse 1 visit a week up to 1 hour a week and Home Health Aide (HHA) 3 visits a day for 6 hours a day, 7 days a week up to 42 hours per week. The record failed to evidence HHA visits were completed on 7/7 and 7/11/13 and failed to evidence 6 hours were provided on 7/8, 9, 10, and 12/13. The record failed to evidence a reason for the missed and shorter visits.</p> <p>A. On 8/13/13 at 3:21 PM, employee A indicated the patient was sick that week and did not want the aides there as long.</p>	G000158	<p>The Director of Nursing is holding a mandatory inservice</p> <p>for all active employees on 08/27/2013,</p> <p>09/06/2013 & 09/ 10/2013 to provide education on Patient</p> <p>Care, following the plan of care and how to appropriately</p> <p>and adequately notify all parties involved when care is not</p> <p>provided in accordance with the physician's orders. The Director</p> <p>of Nursing will review and provide education on the use of the Missed</p> <p>Visit form during the inservice scheduled on 08/27/2013, 09/06/2013</p> <p>& 09/10/2013.</p> <p>The Patient Care Coordinator (PCC) will audit 100% of active</p> <p>Patient's medical records monthly, until 100% percent are</p>	09/10/2013	

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	<p>B. On 8/13/13 at 3:22 PM, employee B indicated the aides reported the patient did not feel good that week and the missed visit forms may not be filed in the chart yet.</p> <p>2. Clinical record #2, SOC date 10/23/12, contained a Home Health Certification and Plan of Care for the certification period 4/21-6/19/13 with orders for Skilled Nurse 1 visit a week up to 2 hours max and HHA 6 hours a day, 5 days a week up to max of 30 hours per week. The record failed to evidence a HHA visit was completed on 4/30/13. The record also failed to evidence a reason the visit was missed.</p> <p>3. Clinical record #3, SOC date 12/5/12, contained a Home Health Certification and Plan of Care for the certification period 6/3-8/1/13 with orders for Skilled Nurse 1 visit a month up to 2 hours a month and HHA 4 hours a day, 3 days a week up to 12 hours a week. The record failed to evidence a HHA visit was completed the week of 6/16/13. The record also failed to a reason the visit was missed.</p> <p>On 8/13/13 at 2:30 PM, employee A indicated patient #3 altered the days they wanted to receive care.</p>		<p>within compliance. Patient's medical records shall be reviewed</p> <p>quarterly thereafter, by the PCC.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>				

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	4. The agency's policy titled "Client Scheduling & Notification of Change" #29, dated 12/2011 states, "B. field staff are responsible for notifying the Staff Coordinator / Scheduler of changes for scheduled visits. ... 3. When a visit can not be provided on the scheduled day, the patient / caregiver will be notified and the visit rescheduled for the next calendar day.			

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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 review, policy review, and interview, the agency failed to ensure the Home Health Aide (HHA) followed the aide care plan for 1 of 3 records reviewed of patients who received HHA services with the potential to affect all the agency's patients who receive HHA services. (#2)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care date 10/23/12, contained a Home Health Certification and Plan of Care for the certification period 4/21-6/19/13 with orders for "Home Health Aide visits 6 hours a day, 5 days a week up to maximum of 30 hours a week thru end of the certification period. ... Assist with personal care, bath, bed linen change, meal prep, medication and O2 reminders. Special attention to skin integrity in peri area due to incontinence issues. Report any change in clients condition, including any increasing pain, shortness of breath, mental changes due to hypoxia to skilled nurse. Fall prevention in place due to increased pain issues and multiple back</p>	G000225	<p>The Director of Nursing is holding a mandatory inservice</p> <p>for all active Home Health Aides on 08/27/2013, 09/0/2013</p> <p>& 09/06/2013 to provide education on the Home Health Aide</p> <p>Care Plan. The Director of Nursing will review with all active</p> <p>Home Health Aides and provide education that care provided</p> <p>to the patient must follow the Home Health Aide Care Plan.</p> <p>The Director of Nursing will review the Home Health Aide Care</p> <p>Plan form during the inservice scheduled on 08/27/2013,</p> <p>09/06/2013 & 09/ 10/2013</p> <p>The Director of Nursing will audit 100% of active</p> <p>Patient's medical records monthly, until 100% are</p>	09/10/2013			

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	<p>surgeries. Equipment will be clean and properly working." The Home Health Aide Plan of Care dated 4/19/13 completed by the Registered Nurse states the tasks to be completed by the HHA were Shower, Shampoo, Hair (brush), Skin (Lotion, Powder, Deodorant) as desired, Assist patient to dress, 1 time a week clean bathroom after bath, light housekeeping (mop, vacuum, dishes, fix meals, snacks), minimal ambulation with assist of cane, Encourage fluids and assist with medications. Report all patient refusal of care to office as soon as possible with reason of refusal.</p> <p>a. The record failed to evidence Shower, Shampoo, Assist with dressing, Skin care, Assist with ambulation, and meal preparation were completed on 5/2, 3, 9, 10, 14, 16, 20, and 21. The record failed to evidence the patient refused the care and that the office was notified.</p> <p>b. The record failed to evidence Shower, Shampoo, Assist with dressing, Skin care, and Assist with ambulation were completed on 5/6, 7, 8, 13,15, and 17 . The record failed to evidence the patient refused the care and that the office was notified.</p> <p>2. On 8/13/13 at 3:00 PM, employee B indicated the aides are to document</p>		<p>within compliance as evidence by documented Home Health Aide</p> <p>care provided follows the patient's Home Health Aide Care Plan. Patient's</p> <p>medical records shall be reviewed</p> <p>quarterly thereafter, by the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>		

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	<p>refusal of care and notify the office, but this patient does have a lot of care done by the aides as the patient cannot do it themselves. Employee B also indicated the patient probably asked the aides not to mark much on their worksheets.</p> <p>3. The agency's policy titled "Services Provided by Discipline" #59, dated 12/2011 states, "2. The RN oversees the patient's personal care provided by the Home Health Aides. A Home Health Aide Care Plan is completed by the RN and reviewed with the Home Health Aide for directions in task assignment prior to the Home Health Aide care provision."</p>			

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G000228	<p>484.36(d)(1) SUPERVISION</p> <p>If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d) (2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) completed the Home Health Aide (HHA) supervisory visits for 1 of 3 records reviewed of patients receiving HHA services with the potential to affect all the agency's patients who receive HHA services. (#2)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care date 10/23/12, contained a Home Health Certification and Plan of Care for the certification period 4/21-6/19/13 with orders for Skilled Nurse and HHA services. The record failed to evidence HHA supervisory visits were conducted by the RN on 5/3 and 5/15/13. The visits were conducted by the Licensed Practical Nurse (LPN).</p> <p>2. On 8/13/13 at 2:40 PM, employee B</p>	G000228	<p>The Director of Nursing reviewed on 08/21/2013 the</p> <p>agency's policy titled "Serviced Provided by Discipline"#59</p> <p>dated 12/2011 and 410 IAC 17-14-1(g) Scope of Services.</p> <p>Inservice scheduled on 08/27/2013 with active licensed</p> <p>clinicians to review and provide education on 410 IAC</p> <p>17-14-1(g) Scope of Services and the agency's policy titled</p> <p>"Serviced Provided by Discipline"#59 dated 12/2011.</p> <p>Director of Nursing will clarify that only the supervising</p> <p>RN can perform supervisory visits. Supervisory</p> <p>visits will be reflected on a separate form, titled "Supervisory Visit</p>	08/27/2013			

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	<p>indicated they usually do the aide supervisory visits since there is not a full time RN and they document the supervisory visits on a separate supervisory note if that is the only reason for the visit. But if they do a SN visit along with a supervisory visit, then it will be charted within the nursing visit notes.</p> <p>3. On 8/14/13 at 12:15 PM, employee A indicated the LPNs do not do supervisory visits.</p> <p>4. The agency's policy titled "Services Provided by Discipline" #59, dated 12/2011 states, "2. The RN oversees the patient's personal care provided by the Home Health Aides. A Home Health Aide Care Plan is completed by the RN and reviewed with the Home Health Aide for directions in task assignment prior to the Home Health Aide care provision. Home Health Aide supervisory visits are completed by the RN no less frequently than every fourteen (14) days either by onsite review with patient/caregiver interview."</p>		<p>Note" from the skilled nurses' notes. Time frames of supervisory visits will be reviewed and education provided to licensed clinicians.</p> <p>The Director of Nursing will audit 100% of active</p> <p>Patient's medical records monthly, until 100% percent are within compliance. Compliance will be evidence by a Supervisory Visit</p> <p>Note present within patient's medical record. Patient's medical records shall be reviewed quarterly thereafter, by the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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G000229	<p>484.36(d)(2) SUPERVISION</p> <p>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, policy review, and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days in 3 of 3 records reviewed of patients who received skilled and home health aide services for longer than 14 days. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 8/1/12, evidenced the patient received skilled and home health aide services for the certification period 5/23-7/21/13. The record failed to evidence a Home Health Aide (HHA) supervisory visit had been completed between 6/13 and 7/11/13.</p> <p>On 8/13/13 at 3:21 PM, employee B indicated there is not a supervisory visit between 6/13 and 7/11/13.</p> <p>2. Clinical record #2, SOC date 10/23/12, evidenced the patient received skilled and home health aide services for the certification period 4/21-6/19/13. The</p>	G000229	<p>The Director of Nursing reviewed on 8/21/2013 the agency's</p> <p>policy titled "Serviced Provided by Discipline"#59 dated 12/2011</p> <p>and 410 IAC 17-14-1(n) Scope of Services.</p> <p>Inservice scheduled on 08/27/2013 with active licensed</p> <p>clinicians to review and provide education on 410 IAC</p> <p>17-14-1(n) Scope of Services and the agency's policy titled</p> <p>"Serviced Provided by Discipline"#59 dated 12/2011.</p> <p>Director of Nursing will clarify the timeframes per policy of when</p> <p>Supervisory Visits are due.</p> <p>The Director of Nursing will audit 100% of active</p> <p>Patient's medical records monthly, until 100% percent are</p>	08/27/2013	

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	<p>record failed to evidence a HHA supervisory visit had been completed.</p> <p>On 8/13/13 at 3:05 PM, employee B indicated the missing supervisory visit was probably done with the resumption of care form which is also not in the chart.</p> <p>3. Clinical record #3, SOC date 12/5/12, evidenced the patient received skilled nurse and home health aide services for the certification period 4/4-6/2/13. The record failed to evidence a HHA supervisory visit had been completed between 4/1 and 5/31/13. The plan of care for the certification period 6/3-8/1/13 also evidenced the patient received HHA services with a skilled nurse visit scheduled for 6/28. The record failed to evidence a HHA supervisory visit was conducted during this certification period. The patient discharged per request on 6/19/13.</p> <p>On 8/13/13 at 2:45 PM, employee B indicated this patient was discharged before the next skilled nurse visit was due, but there had not been a supervisory visit since 5/31.</p> <p>4. The agency's policy titled "Services Provided by Discipline" #59, dated 12/2011 states, "2. The RN oversees the patient's personal care provided by the</p>		<p>within compliance. Compliance will be evidence by a Supervisory Visit</p> <p>Note present within patient's medical record. Patient's medical records</p> <p>shall be reviewed quarterly thereafter, by the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>		

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	Home Health Aides. A Home Health Aide Care Plan is completed by the RN and reviewed with the Home Health Aide for directions in task assignment prior to the Home Health Aide care provision. Home Health Aide supervisory visits are completed by the RN no less frequently than every fourteen (14) days either by onsite review with patient / caregiver interview."			

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NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807		
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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 record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) completed a Resumption of Care assessment following the patient's hospitalization for 1 of 1 clinical record reviewed for a patient with a hospital stay with the potential to affect all the agency's patients who are hospitalized. (#2)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care date 10/23/12, evidenced the patient was in the hospital from 4/22-4/27/13 and on 5/2/13 orders were received for "Resume client to Home Health Care Skilled Nurse 1 visit a week and Home health aide 6 hours a day, 5 days a week for remaining 6 weeks of cert. period. 4/21-6/19/13." The clinical record failed to evidence a Resumption of Care assessment was completed.</p> <p>2. On 8/13/13 at 2:35 PM, employee A indicated this patient refused to have nurses come out and they should have</p>	G000340	<p>The Director of Nursing reviewed on 08/21/2013 the agency's policy on "Care Planning"#22, dated 12/2011 and 410 IAC 17-14-1 (a)(1)(B) Scope of Services.</p> <p>Inservice scheduled on 08/27/2013 with all active RN's to review and provide education on the Resumption of Care process following an inpatient event.</p> <p>The Director of Nursing will audit 100% of active medical charts of patients who have had an inpatient event within the past 6 months. Compliance evidence by ROC completed and present on the patient's medical record per policy/regulations Patient's</p>	08/27/2013	

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	<p>been missed visits.</p> <p>3. On 8/13/13 at 2:55 PM, employee B indicated they did complete the resumption of care, but it may be filed in another patient's chart.</p> <p>4. The agency's policy titled "Care Planning" #22, dated 12/2011 states, "Q. Care Plans must be reviewed when: ... 3. Patient is discharged, transferred and readmitted / resumption of care during the same 60 day episode a minimum of 5 days prior to recertification date."</p>		<p>medical records shall be audited quarterly</p> <p>thereafter by the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>		

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N000000	<p>This was a state Home Health Agency complaint investigation.</p> <p>Complaint #: IN00132043 - Unsubstantiated: Lack of sufficient information. Unrelated deficiencies are cited.</p> <p>Facility #: 012746</p> <p>Survey dates: August 13 and 14, 2013.</p> <p>Medicaid Vendor #: 201061990A</p> <p>Medical Records Reviewed: 3 Closed Records: 2 Active Records: 1</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">August 19, 2013</p>	N000000			

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N000460	<p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:</p> <p>(1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on employee file review, policy review, job description review, and interview, the agency failed to ensure it followed its own policy for a current driver's license upon hire for 1 of 4 employee files reviewed with the potential to affect all the agency's patients. (E)</p> <p>Findings include</p> <p>1. The agency's job description titled "Home Health Aide" dated 4/2010 states, "Position Qualifications: ... Valid Driver's License."</p> <p>2. The agency's policy titled "Personnel Files" dated April 2010 states, "Personnel Files shall include the following: ... 4. Copy of valid driver's license."</p>	N000460	<p>The HR Manager shall audit 100% of active personnel records by 09/06/2013 to ensure compliance with agency's policy which states upon hire, employee's will have a current /valid driver's license, a copy of the current/valid driver's license shall be kept in the employee's personal file.</p> <p>100% of all new hired employees</p>	09/06/2013

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	<p>3. Review of employee file E, a Home Health Aide, date of hire 1/8/13, evidenced the employee's driver's license expired on 12/8/12. The file failed to evidence an updated or current copy of driver's license was obtained.</p> <p>4. On 8/14/13 at 10:50 AM, employee G indicated there was not an updated driver's license in file, but employee did not begin providing care to patients until 3/22/13 and the agency just received notice today that the license was renewed on 3/16/13 but as far as employee G knows, the HHA was not driving to work until then.</p>		<p>HR files shall be audited monthly, by the</p> <p>HR Manager thereafter until 100%</p> <p>are within compliance, as evidence by a copy of current driver's license in personnel file upon hire and onward.</p> <p>Personnel records shall be reviewed quarterly thereafter, by the</p> <p>HR Manager.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>		

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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 review, policy review, and interview, the agency failed to ensure visits were made as ordered on the Plan of Care for 3 of 3 clinical records reviewed with the potential to affect all the agency's patients. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 8/1/12, contained a Home Health Certification and Plan of Care for the certification period 7/22-9/19/13 with orders for Skilled Nurse 1 visit a week up to 1 hour a week and Home Health Aide (HHA) 3 visits a day for 6 hours a day, 7 days a week up to 42 hours per week. The record failed to evidence HHA visits were completed on 7/7 and 7/11/13 and failed to evidence 6 hours were provided on 7/8, 9, 10, and 12/13. The record failed to evidence a reason for the missed and shorter visits.</p> <p>A. On 8/13/13 at 3:21 PM, employee A indicated the patient was sick that week and did not want the aides there as long.</p>	N000522	<p>The Director of Nursing is holding a mandatory inservice</p> <p>for all active employees on 08/27/2013, 09/06/2013</p> <p>& 09/ 10/2013 to provide education on Patient Care, following the plan</p> <p>of care and how to appropriately and adequately notify all</p> <p>parties involved when care is not provided in accordance</p> <p>with the physician's orders. The Director of Nursing</p> <p>will review and provide education on the use of the Missed</p> <p>Visit form during the inservice scheduled on 08/27/2013,</p> <p>09/06/2013 & 09/ 10/2013</p> <p>The Patient Care Coordinator (PCC) will audit 100% of active</p> <p>Patient's medical records monthly, until 100% are</p>	09/10/2013			

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	<p>B. On 8/13/13 at 3:22 PM, employee B indicated the aides reported the patient did not feel good that week and the missed visit forms may not be filed in the chart yet.</p> <p>2. Clinical record #2, SOC date 10/23/12, contained a Home Health Certification and Plan of Care for the certification period 4/21-6/19/13 with orders for Skilled Nurse 1 visit a week up to 2 hours max and HHA 6 hours a day, 5 days a week up to max of 30 hours per week. The record failed to evidence a HHA visit was completed on 4/30/13. The record also failed to evidence a reason the visit was missed.</p> <p>3. Clinical record #3, SOC date 12/5/12, contained a Home Health Certification and Plan of Care for the certification period 6/3-8/1/13 with orders for Skilled Nurse 1 visit a month up to 2 hours a month and HHA 4 hours a day, 3 days a week up to 12 hours a week. The record failed to evidence a HHA visit was completed the week of 6/16/13. The record also failed to a reason the visit was missed.</p> <p>On 8/13/13 at 2:30 PM, employee A indicated patient #3 altered the days they wanted to receive care.</p>		<p>within compliance, as evidence by fulfilling ordered frequencies</p> <p>and duration and or missed visits present in medical chart.</p> <p>Patient's medical records shall be reviewed quarterly thereafter, by the PCC.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>		

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	4. The agency's policy titled "Client Scheduling & Notification of Change" #29, dated 12/2011 states, "B. field staff are responsible for notifying the Staff Coordinator / Scheduler of changes for scheduled visits. ... 3. When a visit can not be provided on the scheduled day, the patient / caregiver will be notified and the visit rescheduled for the next calendar day.			

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N000541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) reassessed the patient when the patient returned home from a hospitalization for 1 of 1 clinical record reviewed for a patient with a hospital stay with the potential to affect all the agency's patients who are hospitalized. (#2)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care date 10/23/12, evidenced the patient was in the hospital from 4/22-4/27/13 and on 5/2/13 orders were received for "Resume client to Home Health Care Skilled Nurse 1 visit a week and Home health aide 6 hours a day, 5 days a week for remaining 6 weeks of cert. period. 4/21-6/19/13." The clinical record failed to evidence a Resumption of Care assessment was completed.</p> <p>2. On 8/13/13 at 2:35 PM, employee A indicated this patient refused to have nurses come out and they should have</p>	N000541	<p>The Director of Nursing reviewed on 08/21/2013 the agency's policy on "Care Planning"#22, dated 12/2011 and 410 IAC 17-14-1 (a)(1)(B) Scope of Services.</p> <p>Inservice scheduled on 08/27/2013 with all active RN's to review and provide education on the Resumption of Care (ROC) process following an inpatient event.</p> <p>The Director of Nursing will audit 100% of active medical charts of patients who have had an inpatient event within the past 6 months. Compliance evidence by ROC completed and present on the patient's medical record per policy/regulations.</p>	08/27/2013	

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	<p>been missed visits.</p> <p>3. On 8/13/13 at 2:55 PM, employee B indicated they did complete the resumption of care, but it may be filed in another patient's chart.</p> <p>4. The agency's policy titled "Care Planning" #22, dated 12/2011 states, "Q. Care Plans must be reviewed when: ... 3. Patient is discharged, transferred and readmitted / resumption of care during the same 60 day episode a minimum of 5 days prior to recertification date."</p>		<p>Patient's medical records shall be audited quarterly thereafter by</p> <p>the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring</p> <p>these corrective actions to ensure that this deficiency</p> <p>is corrected and will not recur.</p>				

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N000584	<p>410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision. Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) completed the Home Health Aide (HHA) supervisory visits for 1 of 3 records reviewed of patients receiving HHA services with the potential to affect all the agency's patients who receive HHA services. (#2)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care date 10/23/12, contained a Home Health Certification and Plan of Care for the certification period 4/21-6/19/13 with orders for Skilled Nurse and HHA services. The record failed to evidence HHA supervisory visits were conducted by the RN on 5/3 and 5/15/13. The visits were conducted by the Licensed Practical Nurse (LPN).</p> <p>2. On 8/13/13 at 2:40 PM, employee B indicated they usually do the aide supervisory visits since there is not a full time RN and they document the</p>	N000584	<p>The Director of Nursing reviewed on 08/21/2013 the agency's policy titled "Serviced Provided by Discipline"#59 dated 12/2011 and 410 IAC 17-14-1(g) Scope of Services. Inservice scheduled on 08/27/2013 with active licensed clinicians to review and provide education on 410 IAC 17-14-1(g) Scope of Services and the agency's policy titled "Serviced Provided by Discipline"#59 dated 12/2011. Director of Nursing will clarify that only the supervising RN can perform supervisory visits. Supervisory visits will be reflected on a separate form, titled "Supervisory Visit Note" from the skilled nurses' notes. Time frames of supervisory visits will be reviewed and education provided to licensed clinicians.</p> <p>The Director of Nursing will audit 100% of active patient's medical records monthly, until 100% percent are within compliance. Compliance will be evidence by a Supervisory Visit Note present within patient's medical record. Patient's medical records</p>	08/27/2013			

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	<p>supervisory visits on a separate supervisory note if that is the only reason for the visit. But if they do a SN visit along with a supervisory visit, then it will be charted within the nursing visit notes.</p> <p>3. On 8/14/13 at 12:15 PM, employee A indicated the LPNs do not do supervisory visits.</p> <p>4. The agency's policy titled "Services Provided by Discipline" #59, dated 12/2011 states, "2. The RN oversees the patient's personal care provided by the Home Health Aides. A Home Health Aide Care Plan is completed by the RN and reviewed with the Home Health Aide for directions in task assignment prior to the Home Health Aide care provision. Home Health Aide supervisory visits are completed by the RN no less frequently than every fourteen (14) days either by onsite review with patient/caregiver interview."</p>		<p>shall be reviewed quarterly thereafter, by the Director of Nursing. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days as required by agency policy in 3 of 3 records reviewed of patients who received skilled and home health aide services for longer than 14 days. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 8/1/12, evidenced the patient received skilled and home health aide services for the certification period 5/23-7/21/13. The record failed to evidence a Home Health Aide (HHA) supervisory visit had been completed between 6/13 and 7/11/13.</p> <p>On 8/13/13 at 3:21 PM, employee B indicated there is not a supervisory visit between 6/13 and 7/11/13.</p> <p>2. Clinical record #2, SOC date 10/23/12,</p>	N000606	<p>The Director of Nursing reviewed on 8/21/2013 the agency's</p> <p>policy titled "Serviced Provided by Discipline"#59 dated 12/2011</p> <p>and 410 IAC 17-14-1(n) Scope of Services.</p> <p>Inservice scheduled on 08/27/2013 with active licensed</p> <p>clinicians to review and provide education on 410 IAC</p> <p>17-14-1(n) Scope of Services and the agency's policy titled</p> <p>"Serviced Provided by Discipline"#59 dated 12/2011.</p> <p>Director of Nursing will clarify the timeframes per policy of when</p> <p>Supervisory Visits are due.</p> <p>The Director of Nursing will audit 100% of active</p>	08/27/2013	

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	<p>evidenced the patient received skilled and home health aide services for the certification period 4/21-6/19/13. The record failed to evidence a HHA supervisory visit had been completed.</p> <p>On 8/13/13 at 3:05 PM, employee B indicated the missing supervisory visit was probably done with the resumption of care form which is also not in the chart.</p> <p>3. Clinical record #3, SOC date 12/5/12, evidenced the patient received skilled nurse and home health aide services for the certification period 4/4-6/2/13. The record failed to evidence a HHA supervisory visit had been completed between 4/1 and 5/31/13. The plan of care for the certification period 6/3-8/1/13 also evidenced the patient received HHA services with a skilled nurse visit scheduled for 6/28. The record failed to evidence a HHA supervisory visit was conducted during this certification period. The patient discharged per request on 6/19/13.</p> <p>On 8/13/13 at 2:45 PM, employee B indicated this patient was discharged before the next skilled nurse visit was due, but there had not been a supervisory visit since 5/31.</p> <p>4. The agency's policy titled "Services</p>		<p>Patient's medical records monthly, until 100% percent are within compliance. Compliance will be evidence by a Supervisory Visit</p> <p>Note present within patient's medical record. Patient's medical records shall be reviewed quarterly thereafter, by the Director of Nursing.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K082	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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	<p>Provided by Discipline" #59, dated 12/2011 states, "2. The RN oversees the patient's personal care provided by the Home Health Aides. A Home Health Aide Care Plan is completed by the RN and reviewed with the Home Health Aide for directions in task assignment prior to the Home Health Aide care provision. Home Health Aide supervisory visits are completed by the RN no less frequently than every fourteen (14) days either by onsite review with patient / caregiver interview."</p>			