STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157543	A. BUILDING 00 B. WING	04/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME CARE HOME HEALTH SERVICES INC	2632 81ST AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N000000	This was a home health state complaint investigation. Complaint #: IN00146418 - Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited. Survey date: April 28 - April 29, 2014 Facility #: 003155 Medicaid vendor #: 200399260 Surveyor: Ingrid Miller RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN May 5, 2014	N000000		
N000446	410 IAC 17-12-1(c)(3) Home health agency administration/management			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on personnel file review, policy review, and interview, the administrator failed to ensure the agency employed qualified personnel for 1 of 2 Home health aide files (F) reviewed with the potential to affect all of the agency patients with home health aide services. Findings 1. Employee File F, Home health aide (HHA) with a date of hire 3/21/14 and first patient contact 4/13/14, failed to evidence the HHA had completed a skills competency evaluation before first patient contact and a job description for a home health aide. 2. On 4/28/14 at 1:50 PM, the director of nursing indicated a competency skills check was needed before the HHA had seen any patients. 3. On 4/29/14 at 3:05 PM, the director of nursing indicated the job description of home health aide was for a nurse	N000446	N 0446 The Assistant Administrator in serviced all Nursing Staff and Home Health Aides on the policy, Home Health Aide Training. The job description for Certified Nursing Assistant revised to incorporate Home Health Aide. A copy of the Home Health Aide job description was given to all Home Health Aides and incorporated into the Home Health Aide orientation package. The revised job description will be presented and discussed at the next scheduled PAC meeting. (7/2014) The skills competency evaluation has been completed on employee F. The Director of Nursing has been certified by the state of Indiana to train and teach CNA/HHA. The Director of Nursing will accompany all newly hired HHA on first contact visit with patient and all current active HHA yearly to observe skills for competency. All newly hired HHA receive a written skill test approved by IAHHC and all incorrect responses are reviewed and discussed with applicant. All HHA receive at the minimum 12 hours of in services yearly. The Office Manager will be responsible for	04/30/2014

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	assistant and not a home health aide. 4. The agency policy titled "Home Health Aide Training" with a revised date of August 2011 stated, "Prime Care Home Health Services, Inc. will only hire individuals as home health aides ... who have completed a training program or a competency evaluation program that meets the organization's criteria."		auditing 100% of all newly hired Home Health Aides employee files to assure compliance is maintained. The Director of Nursing along with the Quality Committee will be responsible for monitoring 10% of all Home Health Aide files to ensure this does not happen again during their quarterly record review. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N000484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record review, interview, and policy review, the agency failed to ensure all personnel providing services and agency management maintained effective communications to assure their efforts appropriately complemented one another and supported the objectives of the patient's care in 1 of 4 records reviewed (#3) with the potential to affect any new patients of the agency. Findings 1. Clinical record #3, start of care	N000484	N 0484 The Director of Nursing in serviced all staff on the policies of Clinical Supervisor and Safeguarding/Retrieval of Clinical/Service Record. All case managers instructed that all admissions must be turned in no later than 5 days after admission. Chain of command notice given to all staff. Employee E and F in serviced and counseled at great length and probationary status lengthen an additional 90 days. All clinical records are locked in records room. The Director of Nursing will audit 100% of all admissions monthly for the next 4	04/30/2014

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	4/13/14, included a plan of care for the certification period of 4/13/14 - 6/11/14. This record was not present in the office until 4/29/14 at 4:40 PM. Employee E, Registered Nurse, had seen the patient on 4/13/14 for the start of care / comprehensive assessment. This had not been communicated to the director of nursing and no record had been completed in the agency office until 4/29/14 at 4:40 PM. a. On 4/29/14 at 9:20 AM, Employee E, registered nurse (RN), indicated caring for patient #3 for the agency and that Employee F was also caring for patient #3. b. On 4/29/14 at 10:05 AM, Employee B, the director of nursing, indicated that Employee F, home health aide (HHA), had brought personnel file documents but had not brought a list of patients since her hire. Employee B indicated patient #3 was not on service at this time. c. On 4/29/14 at 10:15 AM, the administrator indicated Employee F, HHA, was seeing patient #3 on her own since the patient needed bathing and wasn't on service yet. d. On 4/29/14 at 12:30 PM, the		months or until 100% compliance is reached. Then 10% random monthly ongoing to ensure evidence of compliance is maintained. The Quality Committee will be responsible for monitoring 10% of all active cases at their quarterly meeting and a written report will be sent to the Governing Body for their review.	

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	caregiver of patient #3 indicated satisfaction with the services from Employee F, HHA, and Employee E, RN, received through Prime Care. e. On 4/29/14 at 1:10 PM, Employee B, the director of nursing, indicated that patient #3 had started care with the agency and that she had not been aware of this. She did indicate a referral with verbal orders from the physician had been present in the referral book and been given to Employee E, who had not communicated with her about the patient's care since the start of care, and that Employee B was not aware that the patient had started care. Employee E and Employee F had all the documents for this record and had not followed the chain of command or agency policies for turning in documents and coordinating care with her. There was no record in the office at this time for patient #3. f. On 4/29/14 at 4:40 PM, the director of nursing indicated the record for patient #3 had been processed. g. On 4/29/14 at 4:40 PM, the director of nursing was observed to have clinical record #3 in her hand. 2. The agency policy titled "Clinical supervisor" with a revised date of August			

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	2011 stated, "The clinical supervisor is responsible for ensuring that patient care is coordinated and managed appropriately." 3. The agency policy titled "Safeguarding / Retrieval of Clinical / Service Record" with revised date of August 2011 stated, "All patient clinical / service records will be maintained in locked, waterproof file cabinets in a record room: A. All files will be locked at night. B. The clinical / service record room will be locked at night ... 2. All clinical / service records will be returned to the clinical service record room prior to the office closing ... The original clinical / service record for active patients will remain in the office at all times ... records will be retained according to organization policy, local, state, and federal regulations.. records of adult patients will be retained for a minimum of 5 years after discharge."			
N000494	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following:			

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	(1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on clinical record, agency document, and policy review and interview, the agency failed to ensure patients were informed of the patient rights prior to the beginning of care for 1 of 4 patient records reviewed (#3) of patients receiving skilled services from this agency with the potential to affect any new patients of this agency. Findings 1. Clinical record #3, start of care 4/13/14, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. The record evidenced the patient received a Patient Rights document on 4/14/14. The comprehensive assessment was completed on 4/13/14. 2. On 4/29/14 at 4:59 PM, the director of nursing indicated the patient rights were not signed prior to the start of care.	N000494	N 0494 The Administrator in serviced all staff on the policy Home Health Patient Bill of Rights. All case managers instructed to ensure that the patient consent form, which contains acknowledgement of receiving the Patient Bill of Rights, and the date of admission are the same. All case managers were instructed to educate and give patient/caregiver/family the Patient Orientation Booklet which contains the patient rights. All current active patients reissued a copy of the Patient Bill of Rights along with the revised version of Advance Directives. The case managers were educated on the Advance Directives revised July 2013 and copies given to distribute to all current active patients. The Director of Nursing will audit 100% of all admissions monthly and then 100% quarterly for evidence that the patient has been informed of their rights and the handbook was left in the home. The Quality Committee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur during their	04/30/2014

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	3. The agency booklet titled "Patient Orientation for Home Health Care" with no date included a section titled " Your rights & responsibilities as a Health Care patient," the document stated, "As a home care provider, we have an obligation to protect your rights and explain these rights to you in a way you can understand before treatment begins and on an ongoing basis, as needed. Your family or legal representative may exercise these rights for you in the event that you are not competent or able to exercise them for yourself ... You have the right to A. the client has the right to be informed of his or her rights and responsibilities. Prime Care Home Health services will protect and promote the exercise of these rights and responsibilities and maintain documentation to demonstrate compliance. B. The agency will provide the client with written notice of the Client's rights in advance of furnishing care or during the initial evaluation visit before the initiation of care or treatment." 4. The agency policy titled "Home Health Patient Bill of rights" with a revised date of August 2011 stated, "Each patient will be an active, informed participant in his / her plan of care. To ensure this process ... Be informed in advance about care to be furnished and ... changes in the care to		quarterly record review meeting.	

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	be furnished."			
N000518	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced directives, including a description of applicable State law, in 4 of 4 records reviewed (#1 - 4) with the potential to affect all the 52 active patients of the agency. Findings include 1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to	N000518	N 0518 The Administrator inserviced all staff on Advance Directives. The July 2013 revised version of Advance Directives obtained and given to all staff to distribute to their patients. Office Manager given revised version of Advance directives to be placed inside of the Patient Orientation Booklet. A copy of the current Advance Directives has been placed in all Patient Orientation Booklet. The Assistant Administrator will audit 100% of all Patient Orientation Booklets quarterly for evidence the Advance Directives and other pertinent information are current and updated. The Quality Committee will be responsible for monitoring these corrective	04/30/2014

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	the patients at the start of care (SOC). 2. On April 29, 2014 at 3:45 PM, the director of nursing indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patient # 1 - 4's home admission books and that all the patients of the agency needed to receive the updated advanced directives. 3. Clinical record #1, SOC 4/11/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date. 4. Clinical record #2, SOC 3/13/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date. 5. Clinical record #3, SOC 4/13/14 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on 4/14/14. 6. Clinical record #4, SOC 3/10/14,		actions to ensure that this deficiency is corrected and will not recur.	

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	failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.			
N000522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure skilled services were provided as ordered on the plan of care for 2 of 4 (#2 and 4) clinical records reviewed with the potential to effect all patients of the agency that receive skilled services. Findings 1. Clinical record #2, Start of care (SOC) 3/13/14, included a plan of care with a certification period of 3/13/14 - 5/11/14 with orders for the skilled nurse to assess the urinary status of the patient. There were no orders for the frequency and duration of the occupational therapy visits listed in finding a and b. Care failed to follow the written plan of care (POC)	N000522	N 0522 The Director of Nursing in serviced all staff on the policies of Care Planning Process and Physician Participation in Plan of Care. Employee H and Occupational Therapist in serviced extensively and counseled. Addendum written on 4-30-2014 by employee H for urinary supplies and Occupational Therapist for frequency. All staff instructed on the Missed Visit Report when unable to make ordered number of visits weekly. All staff will attempt to make scheduled ordered visits weekly. When unable to make scheduled visits the staff member will notify the office and missed visit report will be completed and faxed to physician's office. All staff are to report to office when unable to make scheduled visit so if applicable arrangements can be made to cover visit with another	04/30/2014

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	as evidenced by the following: a. Occupational therapy visits occurred on 3/20/14, 3/26/14, 3/28/14, and 3/31/14, 4/2/14, 4/9/14, and 4/10/14. b. An occupational therapy evaluation on 3/15/14 failed to evidence the frequency and duration of occupational therapy visits and a signed physician order. c. A nursing visit noted on 3/28/14 evidenced the urinary status was not assessed by the registered nurse, Employee H. d. On 4/29/14 at 3:15 PM, the director of nursing indicated there were no signed orders including frequency and duration of the occupation therapy visits and Employee H did not assess the urinary status of patient #2 at the 3/28/14 visit. 2. Clinical record #4, SOC 3/10/14, included a plan of care for the certification period of 3/10/14 - 5/8/14. Care failed to follow the written POC as evidenced by the following: a. The POC evidenced skilled nurse visits were to be 2 times a week for 2 weeks and then 1 times a week for 7		staff member. The Director of Nursing will audit 100% of all nurses notes, therapy evals, and POC monthly for 3 months then 25% quarterly for evidence that assessments are completed, frequencies are on therapies evaluations, POC is followed, and all missed visit reports are completed with physician notification. The Quality Committee will be responsible for monitoring 10% of all active cases at their quarterly meeting and a written report will be sent to the Governing Body for their review. The Director of Nursing along with the Quality Committee will be responsible for monitoring those corrective actions to ensure that these deficiencies are corrected and will not recur.	

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	weeks. No skilled nurse visit occurred the week of March 30 - April 5th. b. On 4/29/14 at 4 PM, the director of nursing indicated a skilled nurse visit did not occur the week of March 30 - April 5th. 3. The agency policy titled "Care planning process" with a revised date of August 2011 stated, "A written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patient's condition warrants ... the clinical plan of care included Specific procedures to be performed by the therapies, including amount, frequency, and duration ... the plan of care will be based upon the physician's ... orders." 4. The agency policy titled "Physician participation in plan of care" with a revised date of August 2011 stated, "The attending physician will certify the need for the home health care services by signing the plan of care / treatment within 30 days of the start of care ... orders will be reviewed and revised by the patient's physician ... based on changes in the care or service being provided."			

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N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review and interview, the agency failed to ensure the plan of care included a physician signature and frequency and duration of occupational therapy visits for 2 of 4 records reviewed (#2 and 4) with the potential to affect the 52 active patients of the agency.	N000524	N 0524 The Director of Nursing inserviced all nursing staff and therapist on the policy, Physician Participation in Plan of Care. A copy of the policy was sent to all Physicians. The Occupational Therapist inserviced extensively on including the frequency on evaluations. A part time office staff has been hired and duties	04/30/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings 1. Clinical record #2, Start of care (SOC) 3/13/14, included a plan of care with a certification period of 3/13/14 - 5/11/14 that failed to evidence the frequency and duration of the occupational therapy visits listed in finding a and b. a. Occupational therapy visits occurred on 3/20/14, 3/26/14, 3/28/14, and 3/31/14, 4/2/14, 4/9/14, and 4/10/14. b. An occupational therapy evaluation on 3/15/14 failed to evidence the frequency and duration of occupational therapy visits and a signed physician order. c. On 4/29/14 at 3:15 PM, the director of nursing indicated there were no signed orders including frequency and duration of the occupation therapy visits. 2. Clinical record #4, start of care 3/10/14 and diagnosis of congestive heart failure, included a plan of care for the certification period of 3/10/14 - 5/8/14 that was not signed by the physician. On 4/29/14 at 4 PM, the director of nursing indicated the plan of care had not been signed yet by the physician.		include delivering and picking up physician orders. An addendum order written 4/30/2014 for the frequency for OT visits. All staff instructed that no care or visits can be rendered without a physician order. Occupational and Physical Therapists in serviced on frequency, modality, and length of treatment and communication with physician. The Director of Nursing will audit 100% of all clinic records monthly and then 25% quarterly for compliance of physician orders signed and returned in 30 days and frequency of therapy visits are placed on evaluations. The Quality Committee will be responsible for monitoring 10% of all active cases at their quarterly meeting and a written report will be sent to the governing body for their review. The Director of Nursing along with the Quality Committee will be responsible for monitoring those corrective actions to ensure that this deficiency is corrected and will not recur.	

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	157543	A. BUILDING 00 B. WING	04/29/2014

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N000596	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review, policy review, and interview, the agency failed to ensure the home health aide had completed a competency evaluation program for 1 of 2 home health aides reviewed (F) with the potential to affect all patients with Employee F. Findings 1. Employee File F, Home health aide (HHA) with a date of hire 3/21/14 and first patient contact 4/13/14, failed to evidence the HHA had completed a skills competency evaluation before first patient contact. 2. On 4/28/14 at 1:50 PM, the director of	N000596	N 0596 The Director of Nursing in serviced all nursing staff on the policy,Home Health Aide Training on 4/30/2014. A competency skill checklist was performed with employee F on 5/2/2014. The Director of Nursing will perform a competency skill checklist with all newly hired HHA at the time of employment and yearly for all currently employed HHA. At the time of hire all HHA are given a skilled test approved by IAHHC. All incorrect answers are reviewed and discussed with HHA. The Director of Nursing has been certified by the state of Indiana to train and teach CNA/HHA. The Director of Nursing will accompany and observe newly hired HHA in direct care contact and yearly with all current active HHA. All HHA	05/02/2014

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	nursing indicated a competency skills check was needed before the HHA had seen any patients. 3. The agency policy titled "Home Health Aide Training" with a revised date of August 2011 stated, "Prime Care Home Health Services, Inc. will only hire individuals as home health aides ... who have completed a training program or a competency evaluation program that meets the organization's criteria."		receive at least 12 hours of inservices yearly. The Director of Nursing along with the Quality Committee will audit 100% of HHA personnel employee files quarterly for evidence that competency skill checklist are completed. The Director of Nursing will be responsible for monitoring those corrective actions to ensure that this deficiency is corrected and will not recur.	
N000608	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 is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on clinical record and policy	N000608	N 0608 The Administrator in	04/30/2014

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	review and interview, the agency failed to ensure clinical records were maintained in accordance with agency policy for 3 of 4 records reviewed of patients receiving skilled nurse services with the potential to affect all the 52 agency patients (2 - 4). Findings 1. Clinical record #2, start of care (SOC) 3/13/14, evidenced no completed clinical record had been maintained in the agency until after the record was requested. a. On 4/28/14 at 3:02 PM, an occupational therapy evaluation dated 3/15/14 and occupational therapy notes dated 3/20/14, 3/26/14, 3/28/14, and 3/31/14 were observed to be on a very large pile of papers surrounding the director of nursing's desk. Under these notes were approximately 300 - 400 other documents not filed in the office. There were observed to be many other notes behind her desk also not filed. b. On 4/28/14 at 3:05 PM, the director of nursing indicated that clinical record #2 was not in the record room and she did not know where it was. She indicated being behind on filing. c. On 4/28/14 at 3:05 PM, clinical		serviced all staff on the policies of Admission Criteria and Process and Safeguarding/Retrieval of Clinical/Service Record. The Administrator instructed office staff that all admission charts are to be completed within 48 hrs of receiving them in the office. All medical records will be stored in the record room at the end of the day and the record room will be locked. Office staff will only have access to the keys to the record room. All staff has been instructed to turn their notes in weekly. A new office person has been hired to assist with filing records and delivering and retrieving physician orders. The Assistant Administrator and Office Manager will monitor daily that all medical records are stored in the locked record room at the end of each business day. The Assistant Administrator will be responsible for monitoring those corrective actions to ensure that the deficiency is corrected and will not recur.	

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	record #2 was not observed to be in the clinical record room. The director of nursing looked through the documents or clinical record around her desk and was unable to find the documents at this time. d. On 4/28/14 at 3:15 PM, the office manager was observed to put together a folder for clinical record #2. She attached a label for the patient's name on the side of the folder. She continued searching for the clinical record documents. e. On 4/28/14 at 3:30 PM, the clinical record was put together. This record contained the admission agreement and service agreement with the patient rights signed on 3/13/14; a comprehensive nursing assessment completed on 3/13/14; a medicare secondary payer sheet signed on 3/13/14; physician verbal orders for physical therapy to see the patient dated 3/14/14; verbal orders to start care on 3/13/14; a home health certification and plan of care for the certification period of 3/13/14 - 5/11/14; a medication profile with no medications listed and a date of 3/13/14; Occupational Therapy notes from 4/2/14, 4/9/14, and 4/10/14; and nursing notes dated 3/17/14, 3/21/14, 3/25/14, 4/4/14, and 4/11/14.			

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	2. Clinical record #3, start of care 4/13/14, included a plan of care for the certification period of 4/13/14 - 6/11/14. This record was not present in the office until 4/29/14 at 4:40 PM. Employee E, Registered Nurse, had seen the patient on 4/13/14 for the start of care / comprehensive assessment. This had not been communicated to the director of nursing and no record had been completed in the agency office until 4/29/14 at 4:40 PM. a. On 4/29/14 at 9:20 AM, Employee E, registered nurse (RN), indicated caring for patient #3 for the agency and that Employee F, home health aide (HHA), was also caring for patient #3. b. On 4/29/14 at 10:15 AM, the administrator indicated Employee F, HHA, was seeing patient #3 on her own since the patient needed bathing and wasn't on service yet. c. On 4/29/14 at 1:10 PM, Employee B, the director of nursing, indicated that patient #3 had started care with the agency and that she had not been aware of this. She did indicate a referral with verbal orders from the physician had been present in the referral book and been given to Employee E who had not communicated with her about the			

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	patient's care since the start of care, and Employee B was not aware that the patient had started care. Employee E and Employee F had all the documents for this record and had not followed the chain of command or agency policies for turning in documents. There was no record in the office at this time for patient #3. d. On 4/29/14 at 4:40 PM, the director of nursing indicated the record for patient #3 had been processed. e. On 4/29/14 at 4:40 PM, the director of nursing was observed to have clinical record #3 in her hand. 3. Clinical record #4, start of care 3/10/14, evidenced no completed clinical record had been maintained in the agency until after it was requested. a. On 4/28/14 at 3 PM, the director of nursing indicated being unable to find this record. b. On 4/28/14 at 4 PM, the director of nursing presented clinical record #4 with a binder and clinical documents in it. The clinical records included the plan of care for the certification period of 3/10/14 - 5/8/14; the admission consent and service agreement which included the			

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	patient rights consent signed on 3/10/14; nurses notes dated 3/20/14, 3/27/14, 4/17/14, and 4/24/14; a case conference dated 3/10/14; physical therapy visit notes dated 3/18/14, 3/20/14, 3/25/14, 3/27/14, 4/1/14, 4/8/14, 4/10/14, and 4/15/14; and a start of care / comprehensive assessment on 3/10/14. 4. The agency policy titled "Admission Criteria and Process" with a revised date of August 2011 stated, "A clinical record will be initiated for each patient admitted for home health services." 5. The agency policy titled "Safeguarding / Retrieval of Clinical / Service Record" with revised date of August 2011 stated, "All patient clinical / service records will be maintained in locked, waterproof file cabinets in a record room: A. All files will be locked at night. B. The clinical / service record room will be locked at night ... 2. All clinical / service records will be returned to the clinical service record room prior to the office closing ... The original clinical / service record for active patients will remain in the office at all times ... records will be retained according to organization policy, local, state, and federal regulations.. records of adult patients will be retained for a minimum of 5 years after discharge."			

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