

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157562	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2017
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NAME OF PROVIDER OR SUPPLIER  BACK HOME AGAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 291 N STATE RD 2 VALPARAISO, IN 46383
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G 0000  Bldg. 00	<p>This was a federal recertification survey and complaint investigation survey. This survey was fully extended on 6/15/17.</p> <p>Survey dates: 6/8/17 - 6/19/17</p> <p>Complaint #: IN00232243 - Substantiated: Federal deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 003800</p> <p>Medicare #: 157562</p> <p>Unduplicated 12 month census: 118 patients</p> <p>Active Patients: 55</p> <p>Back Home Again is precluded from providing its own home health training and competency evaluation for a period of two years beginning 6/19/17 - 6/19/19 due to being found out of compliance with the Conditions of Participation 42 CFR 484.10 Patient Rights, 484.14 Organization, Services, and Administration, 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.48 Clinical Records,</p>	G 0000		

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 0100  Bldg. 00	<p>and 484.55 Comprehensive Assessment of Patients.</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR 484.10 Patient Rights, 484.14 Organization, Services, and Administration, 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, 484.48 Clinical Records, and 484.55 Comprehensive Assessment of Patients.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patients had been informed of their rights (G 101); failed to ensure the</p>	G 0100	1) As stated for G-101, 102, 108, 109, 110, 116 the agency will revamp patient Start of Care/ Admission Folder to stress Home Health Admission with BHA (Back Home Again), Patient Rights,	08/18/2017

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	<p>patient was provided a written notice of the patient rights in advance of furnishing care to the patient (G 102); failed to ensure that the patient was informed in advance about the care to be furnished by the home health agency (G 108); failed to ensure the patient had been made aware of the right to participate in the planning of care (G109); failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives (G 110); and failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health and the hours of its operation prior to start of care (G 116).</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR 484.10 Patient Rights.</p>		<p>Oasis rights, the ISDH Hot line number and Advance Directives. A copy of all forms returned to the agency will be left with the patient.</p> <p>A. All staff to be re-educated on the Client Admission Process and informing patient of a Home Health Admission with BHA and explanation of the content within the admission folder.</p> <p>B. The new SOC packet will clearly identify BHA on the documentation being left with the patient in their home.</p> <p>C. Whenever possible all Start of Care/Admission Folders are to be placed on top of patients' refrigerator for consistent location/access.</p> <p>D. Every visit staff will remind the patient that their visit is for their Home Health admission with BHA and document in the patient note.</p> <p>E. Each visit with a patient is to be signed on a paper tracking log that clearly states patient is aware they have completed a visit for Home Health Care with agency BHA.</p> <p>F. Rights will be given before care is initiated.</p> <p>G. Home Health Agency Care will be provided in the patients' residence.</p> <p>2) Chart Audits for items C, D &amp; E to be completed on new admissions beginning after 08/04/17 with the new SOC packets. The audits will be for 3 months &amp; then 10% with quarterly</p>		

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G 0101 Bldg. 00	<p>484.10 PATIENT RIGHTS</p> <p>The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on home visit observation, record review, and interview, the agency failed to ensure patients had been informed of their rights in 8 (# 1, 2, 4, 5, 6, 9, 10, 11) of 12 records reviewed.</p> <p>The findings include:</p> <p>1. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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</p>	G 0101	<p>audits.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/18/2017</p> <p>1)Agency will revamp patient Start of Care/ Admission Folder to stress Home Health Admission with BHA (Back Home Again), Patient Rights and Advance Directives. A copy of all forms returned to the agency will be left with the patient.</p> <p>A. All staff to be re-educated on the Client Admission Process and informing patient of a Home Health Admission with BHA and explanation of the content within the admission folder.</p> <p>B. The new SOC packet will clearly identify BHA on the documentation being left with the patient in their home.</p> <p>C. Whenever possible all Start of Care/Admission Folders are to be placed on top of patients' refrigerator for consistent location/access.</p> <p>D. Every visit staff will remind the patient that their visit is for their Home Health admission with BHA and document in the patient note.</p> <p>E. Each visit with a patient is to be signed on a paper tracking log that clearly states patient is aware</p>	08/18/2017

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	<p>this section. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the</p>		<p>they have completed a visit for Home Health Care with agency BHA. F. Home Health Agency Care will be provided in the patients' residence. Staff will be reeducated that all therapy is to be done and documented in the patients' place of residence. Staff re-educated on Palmetto GBA's &amp; LCD for PT &amp; OT documentation. G. All current patients will receive the new Patient Information Booklet/Folder implemented 08/04/17. Each patient will sign receipt of information. 2) Chart Audits for items C, D &amp; E to be completed on new admissions beginning after 08/04/17 with the new SOC packets. The audits will be for 3 months &amp; then 10% with quarterly audits. 3) Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance is 08/18/2017</p>	

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	<p>state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>2. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home</p>						

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	<p>health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of a rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of the patient rights:</p>				

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	<p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would</p>			

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	<p>approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>4. Regarding patient #5 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care.</p>			

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	<p>This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>5. Regarding patient #6 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p>			

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	<p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>6. Regarding patient # 9 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and had never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>7. Regarding patient # 10 who did not receive an admission folder until the day before the home visit observation:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home</p>			

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	<p>health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>8. Regarding patient # 11 who did not receive an admission folder until day of home visit observation:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p>			

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	<p>B. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving an admission folder booklet today and not having the booklet including the patient rights before today (6/13/17).</p> <p>C. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>9. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an</p>			

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	<p>explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit.</p>			

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	<p>K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>10. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable</p>			

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	<p>to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>11. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>12. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make</p>			

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	<p>decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>Regarding patient #2</p> <p>13. A review of Clinical Record #2 evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>A. The agency booklet titled "Patient Orientation for Home Health Care" dated</p>			

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	<p>3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights ... You also have the right to ... receive information in a manner you can understand ... be advised of the availability of the toll free home health agency [HHA] hotline in the state."</p> <p><b>B. During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence written notice of patient's rights to include OASIS rights. Patient #2 stated not having discarded agency documents provided at the start of care and could not recall the name of the clinician who came to the home on 2-16-17.</b></p>				

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G 0102  Bldg. 00	<p>484.10(a)(1) NOTICE OF RIGHTS</p> <p>The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the patient was provided a written notice of the patient rights in advance of furnishing care to the patient for 8 (# 1, 2, 4, 5, 6, 9, 10, 11) of 12 records reviewed.</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of</p>	G 0102	<p>1) In addition to measures to be completed per N 494 the agency will ensure all patients are informed in writing at admission of the disciplines that will provide care during the Home Health Episode and each clinician is to outline the anticipated frequency of visits for the patient.</p> <p>A. Staff will be educated on communicating anticipated frequency with their patients and documenting on a calendar to be left in the admission folder in the patients' home. This includes revisions/updates to the Plan of Care involving</p>	08/18/2017

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home</p>		<p>disciplines and frequencies recorded on the patient calendar in their admission folder.</p> <p>B. The revamped Start of Care/Admission folder will include blank calendars as well as a checklist of items (left in the home and returned to the office) that includes calendars and patient acknowledgement of calendar.</p> <p>C. Patient will be notified in writing of any changes in disciplines and / or frequency recorded on the patient calendar in their admission folder.</p> <p>2) The Clinical Manager will review/audit all new SOC documentation for compliance of items B &amp; C. Audits to be completed with 100% of new admissions 08/04/17 for 3 months and then 10% quarterly.</p> <p>3) Administrator Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance is 08/18/17.</p>	

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	<p>health agency patient or that the patient did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home</p>			

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	<p>health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home</p>			

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	<p>health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of</p>			

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	<p>operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient</p>			

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	<p>[including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. Regarding patient # 10 who did not receive an admission folder until the day before the home visit observation:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of</p>			

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>7. Regarding patient # 11 who did not receive an admission folder until day of home visit observation:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of</p>			

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	<p>operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>C. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>8. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order</p>			

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	for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature			

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	<p>on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>9. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing</p>			

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	<p>care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>10. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before</p>			

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	<p>the start of care."</p> <p>11. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>12. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's A. In advance of furnishing care to the patient; or B. during the initial evaluation visit before the initiation of treatment. 2.</p>			

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	Maintain Documentation showing that it has complied with the requirements of this section. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient			

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	<p>in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>13. Regarding patient #2:</p> <p>A. A review of Clinical Record #2 evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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G 0108 Bldg. 00	<p>has solicited or coerced my decision in selecting a home health agency." <b>B.</b></p> <p>During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence written notice of patient's rights to include OASIS rights. Patient #2 stated not having discarded agency documents provided at the start of care and could not recall the name of the clinician who came to the home on 2-16-17.</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in</p>			

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	<p>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 record review and interview, the agency failed to ensure that the patient was informed in advance about the care to be furnished by the home health agency in 5 of 12 records reviewed (# 1, 4, 5, 6, 9).</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of receiving care from the agency:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and</p>	G 0108	<p>1) 1) The agency will ensure all patients are informed in writing at admission and as an ongoing procedure of the disciplines that will provide care during the Home Health Episode and each clinician is to outline the anticipated frequency of visits for the patient.</p> <p>A. Staff will be educated on communicating anticipated frequency with their patients and documenting on a calendar to be left in the admission folder in the patients' home. This includes revisions/updates to the Plan of Care involving disciplines and frequencies recorded on the patient calendar in their admission folder.</p> <p>B. The revamped Start of Care/Admission folder will include blank calendars as well as a checklist of items (left in the home and</p>	08/18/2017

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	<p>explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home</p>		<p>returned to the office) that includes calendars and patient acknowledgement of calendar.</p> <p>C. Patient will be notified in writing of any changes in disciplines and / or frequency recorded on the patient calendar in their admission folder.</p> <p>2) The Clinical Manager will review/audit all new SOC documentation for compliance of items B &amp; C. Audits to be completed with 100% of new admissions 08/04/17 for 3 months and then 10% quarterly.</p> <p>3) Administrator Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance is 08/18/17.</p>		

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	<p>health agency or aware of receiving care from the agency:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to</p>			

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	<p>send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p>			

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	<p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and</p>			

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	<p>explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the</p>				

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	initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any				

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	<p>possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>7. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client</p>				

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	with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider ... when the client / caregiver has reviewed the Bill of Rights and their right to complain to the agency, they are also given the numbers and contact information for the Home Care Hotline operated by the Department of Health."			

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	<p>8. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>9. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>10. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home</p>			

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	<p>health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ...</p>			

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G 0109  Bldg. 00	<p>have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to participate in the</p>			

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	<p>planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on record review and interview, the agency failed to ensure that the patient was informed in advance about the right to participate in the planning of care to be furnished by the home health agency in 5 of 12 records reviewed (# 1, 4, 5, 6, 9).</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of receiving care from the agency</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>	G 0109	<p>1)The agency will ensure all patients are informed in writing at admission and on an ongoing basis the disciplines that will provide care during the Home Health Episode and each clinician is to outline the anticipated frequency of visits for the patient. All patients will be informed in advance about participating in their care planning by having visits identified in advance on a calendar provided in the Start of Care/ Admission Folder and reminder cards distributed by the clinician for the next anticipated visit. Care planning with patient involvement will be documented at each visit. Should changes need to be made to the Plan of Care the patient will be notified in writing prior to providing care.</p> <p>A. Staff will be educated on communicating anticipated frequency with their patients and documenting on a calendar to be left in the admission folder in the patients' home. This includes revisions/updates to the Plan of Care involving disciplines and frequencies recorded on the patient calendar in their</p>	08/18/2017			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of receiving care from the agency</p>		<p>admission folder.</p> <p>B. The revamped Start of Care/Admission folder will include blank calendars as well as a checklist of items (left in the home and returned to the office) that includes calendars and patient acknowledgement of calendar.</p> <p>C. Patient will be notified in writing of any changes in disciplines and / or frequency recorded on the patient calendar in their admission folder.</p> <p>D. Staff will be educated on utilization of the calendar and distribution of reminder cards. If a reminder card is distributed it is to be documented in the patient note.</p> <p>2) For items A-C the Clinical Manager will review/audit all new SOC documentation for compliance of items B &amp; C. This will be ongoing with 100% compliance. For item D the agency will contact patient the day before the next scheduled visit to remind them of their next scheduled visit. A log of daily contact will be kept at the agency and these along with 10% of patient notes to be reviewed weekly by the clinical manager for 100% compliance for 3 months and then 10% quarterly.</p> <p>3) Administrator Clinical</p>		

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	<p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p>		<p>Manager (DON) are responsible. 4) Date of compliance is 08/18/17.</p>				

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	<p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending</p>			

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	<p>outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on</p>			

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	<p>6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in</p>				

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	<p>selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the</p>			

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	<p>client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by</p>			

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	<p>the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit.</p> <p>K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>7. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is</p>						

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	<p>initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider ... when the client / caregiver has reviewed the Bill of Rights and their right to complain to the agency, they are also given the numbers and contact information for the Home Care Hotline operated by the Department of Health."</p> <p>8. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of</p>			

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	<p>their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>9. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>10. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's A. In</p>			

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	<p>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. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency</p>			

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G 0110 Bldg. 00	<p>[HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p>			

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	<p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives in 8 (# 1, 2, 4, 5, 6, 9, 10, 11) of 12 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of Clinical records #1, 4, 5, 6, 9, 10, 11 failed to evidence the most current version of the description of Indiana state law regarding advance directives, "Your Right To Decide", dated July 2013, had been provided to the patients at the start of care. This is evidenced by the following:</li> <li>2. A review of the admission handbook for the agency titled "Back Home Again Inc Home Health Care Services ... Patient Orientation &amp; Information" included the Indiana State Department of Health Advance Directives Your Right to Decide Revised May 2004.</li> </ol>	G 0110	<ol style="list-style-type: none"> <li>1) The Agency will ensure that patients receive the most current description of the Indiana State Health Department Advance Directives (Revised July 1, 2013) in the revamped Start of Care/ Admission folder.               <ol style="list-style-type: none"> <li>A. Admitting and all clinical staff to be educated on the most current version of Advance Directives so they may ensure patient has the most current version.</li> <li>B. Extra copies of the most current version of Advance Directives (Revised July 1, 2013) to be distributed to have on hand to give to patients if outdated versions are identified in current patient homes.</li> <li>C. The primary professional in the home is to review at recertification the advance directive in the home and document findings in their clinical note.</li> </ol> </li> <li>2) The Clinical Manager will review the SOC checklist for receipt of the updated Advance Directives as well as audit recertification for inclusion of documentation of Advance Directives in the patient home</li> </ol>	08/18/2017

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	<p>3. A review of the "Back Home Again Patient Orientation for Home Health Care" dated 3/17 included a section titled "Section III: Patient Rights and Responsibilities" stated, "The patient or the patients 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 ... The patient has the right to be as follows ... the home health must inform and distribute written information to the patient in advance concerning its policies on advance directives, including a description of state law. The home health agency may furnish advance directive information to a patient at the time of the first home visit, as long as the information is furnished before care is provided."</p> <p>4. Regarding patient #1 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient</p>		<p>with quarterly chart audits. Audits to be completed on 100% of new admissions 08/04/17 for 3 months and then 10% quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance 08/18/17.</p>	

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	<p>[including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of</p>			

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	<p>anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>5. Regarding patient #4 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990</p>						

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	<p>requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>6. Regarding patient #5 who was not</p>			

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	<p>aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending</p>			

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	<p>outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>6. Regarding patient #6 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990</p>			

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	<p>requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>7. Regarding patient # 9 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of</p>			

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ...</p> <p>Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p>						

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	<p>8. Regarding patient # 10 who was not aware of receiving the most current description of Indiana state law regarding advance directives at the start of care:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p>			

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	<p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>9. Regarding patient # 11 who did not receive an admission folder until day of home visit observation or have knowledge of advance directives:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be</p>			

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	<p>known when I am unable to speak for myself."</p> <p>B. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights ... You also have the right to ... receive information in a manner you can understand ... be advised of the availability of the toll free home health agency [HHA] hotline in the state."</p> <p>C. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>D. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>10. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate</p>			

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	<p>for admission. These standards include:</p> <p>a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided</p>			

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	<p>in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>11. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make</p>			

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	<p>informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home</p>			

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	<p>health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>12. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>13. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>14. Regarding patient #2 who did not receive the advance directives in the admission folder:</p>			

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	<p>A. A review of patient #2's clinical record evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be</p>			

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	<p>informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights ... You also have the right to ... receive information in a manner you can understand ... be advised of the availability of the toll free home health agency [HHA] hotline in the state." C. During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence failed to evidence written notice of a description of applicable Indiana Advance Directive law; and failed to evidence documentation of the agency's policies related to advance directives had been provided. Patient #2 stated not having discarded any documents from the admission folder and could not recall the name of the clinician who visited the home on 2-16-17, when admission procedures were accomplished. Review of a consent, "Admission Consent," dated 2-16-17, evidenced patient #2 had checked the boxes indicating having a living will and durable power of attorney</p>			

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G 0116 Bldg. 00	<p>as advance directives. Patient #2 stated not having provided copies of the documents to the agency, and not having been asked by any agency personnel to provide a copy of the 2 advance directives to the home health agency. Patient #2 denied anyone from the agency had explained the agency's policies related to Advance Directives.</p> <p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p>			

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	<p>Based on home visit observation, record review and interview, the agency failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health and the hours of its operation for 8 of 12 patients (#1, #2, #4, #5, #6, #9, #10, #11) prior to start of care.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of the agency admission booklet titled "Back Home Again Patient Orientation for Home Health Care" dated 3/17 stated, "Section III. Patient Rights and Responsibilities" stated, "You also have the right to ... be advised of the availability of the toll free home health agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's Toll free hotline number is 1 - 800 - 227 - 6334."</li> <li>2. A review of the undated agency admission folder titled "Back Home</li> </ol>	G 0116	<ol style="list-style-type: none"> <li>1) The Agency will ensure each patient has ready access to the State toll-free HHA Hotline to file a complaint with the department. The agency will have the phone numbers (and hours of operation) to register a complaint included on the label for the Start of Care/ Admission Folder to BHA as well as on a magnet that will be placed on the patients' refrigerator at admission. <ul style="list-style-type: none"> <li>A. Staff will be educated on the admission process and the importance of explaining the patient rights and where to locate numbers to call if a patient has a complaint.</li> <li>B. New labels will be made for the Start of Care/Admission Folders and distributed to current patients along with the magnets. Extra magnets to always be available to replace if one is discovered missing with follow up visits. The magnet will contain information for how to contact the agency administrator, Clinical Manager, as well as the hotline number and hours for the ISDH.</li> </ul> </li> <li>2) Clinical Manager will review/audit all SOC documentation and processes to ensure patient rights are explained. Calls will be made to patients to ensure item B is understood by the patients. A telephone call will be made to the patients' home within one week of admission to ensure they understand where to locate the number to call for a complaint.</li> </ol>	08/18/2017	

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	<p>Again ... Patient Orientation and Information" evidenced the admission booklet in fining #1 above.</p> <p>3. A review of the admission consent evidenced the following statement: "This form is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval. Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>4. A review of clinical records # 1, 2, 4, 5, 6, 9, 10, and 11 evidenced signed consents on the start of care date. Interviews and observations below evidence the lack of knowledge that the patients had concerning the Indiana Department of Health Hotline number:</p> <p>5. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of the patient</p>		<p>Call to be documented in patient chart under patient communication. Audits to be completed on 100% of new admissions 08/04/17 for 3 months and then 10 % quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/18/17.</p>	

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	<p>rights:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of</p>			

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	<p>anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>6. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on</p>			

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	<p>6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>7. Regarding patient #5 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and</p>			

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	<p>Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>8. Regarding patient #6 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with</p>			

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	<p>the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>9. Regarding patient # 9 who was not aware of being a patient of the home health agency or aware of the patient rights:</p>			

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	<p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>10. Regarding patient # 10 who did not receive an admission folder until the day</p>			

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	<p>before the home visit observation:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>11. Regarding patient # 11 who did not receive an admission folder until day of home visit observation:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with</p>			

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	<p>the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>C. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>12. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated</p>			

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	<p>by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ...</p> <p>9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the</p>			

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	<p>client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>13. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint</p>			

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	<p>mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p>			

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	<p>14. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>15. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>16. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through</p>			

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	<p>effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is</p>			

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	<p>provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>17. Regarding patient #2:</p> <p>A. A review of Clinical Record #2 evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of</p>			

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency." B.</p> <p>During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence the state home health hotline had been provided in writing to patient #2. Patient #2 stated not having discarded any documents from the admission folder and could not recall the name of the clinician who visited the home on 2-16-17, when admission processes were accomplished. Patient #2 stated if a concern or complaint developed, would contact someone in "the gym." [an outside agency's therapy room located on the 2nd floor of the building]</p>						

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G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION  Based on observation, record review and interview, it was determined the administrator failed to protect the patient's right to understand the care to be provided by the agency for 8 of 12 records reviewed, failed to evidence an accurate home visit schedule for 1 of 1 agency, failed to evidence accurate documentation for initial / comprehensive assessments to determine eligibility for the Medicare Home Health benefit including homebound status for 6 of 12 records reviewed, and failed to evidence patients received therapy services inside the patients' place of residence for 7 of 12 records reviewed (see G 133); and failed to ensure the agency appointed a qualified registered nurse for the alternate supervising nurse position for 1 of 1 agency (see G 139 and G 141).	G 0122	1)The administrator & clinical manager/HR manager will review the hiring policies and procedures for compliance. The administrator will inform the PAC, Governing Body & staff on the conditions and standards that were identified on the statement of deficiencies G-100, 101, 102, 108, 109, 110, 116, 331 & 335. This information includes the plans for correction of deficiencies. The Governing Body, PAC, & staff will be informed concerning results from the audits being done x3 months & quarterly. Documentation of report will be included in the Governing Body and PAC minutes & staff inservice.	08/18/2017

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G 0133  Bldg. 00	<p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR 484.14 Organization, Services, and Administration.</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among</p>		<p>A. The agency will initiate an outside source for verification of employment of all future applicants considered for open positions.</p> <p>B. Applicants will not be scheduled for orientation until the administrator has reviewed and approved an applicant for hire.</p> <p>2) HR audits of new hires to be completed by the HR manager on 100% of all new hires. This is ongoing. The audits for G-100, 101, 102, 108, 109, 110, 116, 331 &amp; 335 will be done to bring 484.14(c) into compliance. Audits to be completed with 100% of new admissions 08/04/17 for 3 months and then 10% quarterly.</p> <p>3) Administrator is responsible.</p> <p>4) Date of Compliance is 08/18/17.</p>	

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	<p>the governing body, the group of professional personnel, and the staff.</p> <p>Based on home visit observation, record review and interview, the administrator failed to protect the patient's right to understand the care to be provided by the agency for 8 of 12 records reviewed ( # 1, 2, 4, 5, 6, 9, 10, 11), failed to evidence an accurate home visit schedule for 1 of 1 agency, failed to evidence accurate documentation for initial / comprehensive assessments to determine eligibility for the Medicare Home Health benefit including homebound status for 6 of 12 records reviewed, and failed to evidence patients received therapy services inside the patients' place of residence for 8 of 12 records reviewed (#1, #2, 3, 4, 5, 6, 9, 11).</p> <p>The findings include:</p> <p>1. Regarding the patient's right to have knowledge of being a patient of the home health agency and receiving/understanding the patient rights documents prior to the start of care:</p> <p>A. A review of the agency admission booklet titled "Back Home Again Patient Orientation for Home Health Care" dated 3/17 stated, "Section III. Patient Rights and Responsibilities" stated, "The patient</p>	G 0133	<p>1) A. PATIENT RIGHTS: As stated for G-101, 102, 108, 109, 110, 116 the agency will revamp patient Start of Care/ Admission Folder to stress Home Health Admission with BHA (Back Home Again), Patient Rights, Oasis rights, the ISDH Hot line number and Advance Directives. A copy of all forms returned to the agency will be left with the patient.</p> <p>i. All staff to be re-educated on the Client Admission Process and informing patient of a Home Health Admission with BHA and explanation of the content within the admission folder.</p> <p>ii. The new SOC packet will clearly identify BHA on the documentation being left with the patient in their home.</p> <p>iii. Whenever possible all Start of Care/Admission Folders are to be placed on top of patients' refrigerator for consistent location/access.</p> <p>iv. Every visit staff will remind the patient that their visit is for their Home Health admission with BHA and document in the patient note.</p> <p>v. Each visit with a patient is to be signed on a paper tracking log that clearly states patient is aware they have completed a visit for Home Health Care with agency BHA.</p> <p>vi. Rights will be given</p>	08/18/2017

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	<p>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 promote the exercise of these rights and shall do the following: Provide the patient with a written notice of the patient's rights. [A] in advance of furnishing care to the patient or [B] during the initial evaluation visit before the initiation of treatment ... You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct. To have ethical issues addressed, and inform you of standards of conduct ... choose your health care providers and communicate with those providers."</p> <p>B. A review of the undated agency admission folder titled "Back Home Again ... Patient Orientation and Information" evidenced the admission booklet in finding #1 above.</p> <p>C. A review of clinical record #1, #2, #4, #5, #6, #9, #10, and #11 evidenced the patient's signatures on the admission document which stated, "This form is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval. Patient Rights and</p>		<p>before care is initiated.</p> <p>vii. Home Health Agency Care will be provided in the patients' residence.</p> <p>B. INITIAL ASSESSMENT: The agency will immediately complete an accurate initial assessment of all patients to determine admission for a home health episode which may include a comprehensive assessment. Medicare patients not accepted for admission following initial assessment will receive the CMS NOMNC.</p> <p>i. All direct care staff (RN, PT, OT &amp; ST) will receive reeducation and training on completing an accurate initial patient assessment. Admitting professional shall document immediate care &amp; support needs and homebound status for Medicare. This includes skilled &amp; Paraprofessional needs. This includes coordination of care with team members to identify discrepancies in clinical data and patient criteria for admission.</p> <p>ii. The agency will contract an external QA</p>		

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	<p>Responsibilities I acknowledge receipt of my rights and responsibilities [including OASIS rights] and I understand them. These signatures were dated at the start of care (Please refer to G 100 and G 101, G 102, G 108, G 109, G 110, G 116).</p> <p>D. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of the client's rights ... Special Instructions</p> <p>1. A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated."</p> <p>2. Regarding accurate skilled nurse documentation for initial / comprehensive assessments (see G 331 and G 335):</p> <p>A. The administrator failed to</p>		<p>(associated with the new EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. Final review and submission to be approved by the Clinical Manger or alternate. All modifications to the original submission to be documented on a modification revision form, signed by all parties, and incorporated into the patients' chart. The Clinical Manager will review the external QA report before locking Oasis.</p> <p>C. PATIENT RIGHTS: Staff will be reeducated that all therapy is to be done and documented in the patients' place of residence. Staff re-educated on Palmetto GBA's &amp; LCD for PT &amp; OT documentation.</p> <p>D. ADMINISTRATOR: The administrator will inform the PAC, Governing Body &amp; staff on the conditions and standards that were identified on the statement of deficiencies</p>		

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	<p>evidence accurate documentation for initial / comprehensive assessments to determine eligibility for the Medicare Home Health benefit including homebound status for 6 of 12 records reviewed (see G 331 and G335).</p> <p>3. Regarding an inaccurate home visit schedule:</p> <p style="padding-left: 40px;">A. A review of the agency skilled nurse visit schedule on 6/9/17 at 9 AM failed to evidence a skilled nurse visit occurred with patient #2. This was evidenced by the following:</p> <p style="padding-left: 80px;">i. A document titled "Column Appointments" with a date of 6/9/17 evidenced a 9 AM agency appointment scheduled with Employee B, RN. This visit did not occur as listed on the home visit calendar.</p> <p style="padding-left: 80px;">ii. During a home visit observation of a home health aide for patient #2, on 6-9-17 at 9:00 AM, patient #2 was observed to have a home visit with Employee O, Home Health Aide.</p> <p style="padding-left: 80px;">iii. During an interview on 6/19/17 at 5:40 PM, the director of nursing and the pending administrator indicated the schedule was constantly changing.</p>		<p>G-100, 101, 102, 108, 109, 110, 116, 331 &amp; 335. This information includes the plans for correction of deficiencies. The Governing Body, PAC, &amp; staff will be informed concerning results from the audits being done x3 months &amp; quarterly. Documentation of report will be included in the Governing Body and PAC minutes &amp; staff inservice.</p> <p>2) The ongoing audits for G-100, 101, 102, 108, 109, 110, 116, 331 &amp; 335 will be done to bring 484.14(c) into compliance. Audits to be completed with 100% of new admissions 08/04/17 for 3 months and then 10% quarterly. Chart Audits for items A, B, C to be completed on new admissions beginning after 08/04/17 with the new SOC packets. The audits will be for 3 months &amp; then 10% with quarterly audits.</p> <p>3) The Administrator is responsible.</p> <p>4) Date of compliance to be 08/18/17.</p>		

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	<p>4. Regarding therapy occurring in a therapy rehab room outside the patient's residence in assisted living / independent living facilities:</p> <p>A. A review of clinical records and interviews with patients evidenced the patient received therapy in the "rehab room" and not in the patient's place of residence or home. This was evidenced by the following:</p> <p>i.. During a phone interview on 6/11/17 at 6:40 PM, patient #11 indicated receiving physical therapy services in a rehab room. Patient #11 indicated no other services have occurred besides this therapy which was mostly posture training.</p> <p>ii. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>iii. During a phone interview on 6/11/17 at 7:10 PM, Patient #4 indicated being completely independent with all personal care and attending therapy in a</p>			

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	<p>therapy room and that now rehabilitation was finished. Patient #4 indicated working on strength and endurance. Patient #4 indicated being told that therapy care was on an inactive list due to a report needing to be sent in and approved for her / him to continue with care.</p> <p>a. A review of a COTA visit dated 5/11/17 stated, "Pt completes 3 minutes of forward propulsion on BUE Bike, takes short rest break then completes 3 minutes backward."</p> <p>iv. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>v. During an interview on 6/13/17 at 8:50 AM, patient #13, informal caregiver of patient #3 indicated that scheduling cards were placed in the patient's door the evening before therapy. That was how the patients knew when therapy would be. Patient #13 indicated attending physical therapy in the rehab room.</p>			

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	<p>a. A review of a treatment note: Occupational Therapy completed by Employee E, Certified occupational therapy assistant visit dated 3/22/17 stated, "Pt completes 10 minutes Nu Step machine."</p> <p>b. A review of a COTA (certified occupational therapy assistant) visit dated 5/22/17 completed by Employee E, COTA stated, "Pt completes X 10 minutes of Nu - Step machine."</p> <p>c. A review of the clinical record #3 evidenced a treatment note: physical therapy completed by Employee C, PTA (physical therapy assistant). This note stated, "Pt warmed up on Nu - Step machine."</p> <p>d. A review of the clinical record #3 evidenced a physical therapy revisit note dated 5/8/17 with a time of 10:15 AM which stated, "Seated Standing exercises Nu - Step machine performed." This was completed by PTA, Employee C.</p> <p>vi. During an observation of a physical therapy rehabilitation room on 6/13/17 at 9:38 AM, approximately 15 patients were observed to be seated on bikes and other equipment. This</p>			

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	<p>observation was at an independent living / assistant living / memory care facility with Employee A, physical therapist, accompanying.</p> <p>vii. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated having physical therapy and occupational therapy in therapy room. She did not recall meeting a nurse from the agency.</p> <p>viii. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time/person/place) and not aware of home bound status for this patient.</p> <p>ix. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home</p>			

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	<p>health agency.</p> <p>a. A review of the clinical record #1 evidenced a physical therapy visit on 13:33 PM and evidenced the patient completes 10 minutes of Nu-Step machine.</p> <p>b. A review of the clinical record #1 evidenced that on 5/25/17 at 2:10 PM at a physical therapy assistant visit evidenced the patient warmed up on a Nu - Step machine.</p> <p>c. A review of the clinical record #1 evidenced that on 6/1/17 at 1:36 PM at a physical therapy assistant visit evidenced the patient did exercises on a Nu - Step machine.</p> <p>5. During an interview with the alternate administrator / director of nursing on 6/15/17 at 11:40 AM, the alternate administrator / director of nursing indicated acknowledgement of concern that the patients had not received the admission booklets / patient rights documents and were not involved in planning their care and were receiving scheduling notes in their doors the evening before the therapy rehab room visits.</p> <p>6. The undated agency policy titled</p>				

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	"Therapy Services" stated, "Therapy Services are an integral part of the interdisciplinary scope of services offered by the agency. Therapist shall provided services as determined by assessments and as per physician orders. Purpose To provide optimum quality care to patients, To provide guidelines for therapy services and care coordination with other disciplines, To comply with state / federal guidelines. Special Instructions 1. Referrals to the agency for therapy services [Physical, Speech, Occupational] my include, but are not limited to: a. Observation and evaluation b. Teaching and Training c. Direct therapy procedures d. Overall development of an individualized therapy program under the direction of the physician ... 4. If therapy services are ordered at the start of care when nursing is doing the initial assessment, therapy will do the initial assessment within 5 days of start of care or document need for other schedule. The 2011 Home Health PPS rule clarified policies regarding coverage of therapy services to assist agencies and curb misuse of benefit. The rule requires the following: 5. Measurable treatment goals be described in the plan of care and the patient's clinical record would demonstrate that the method used to assess a patient's function would include objective measurement or progress			

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	<p>towards goals and / or therapy effectiveness."</p> <p>7. The undated agency policy titled "Medicare Qualifying Criteria for Beneficiary Reimbursement" stated, "To accept a client for care under Medicare reimbursement, the client must meet qualifying criteria as outlined in the HIM - 11 [CMS Home Health Agency Manual in the CFR 24 S93 Section 409.2]. Purpose: To provide written guidelines for determining whether clients qualify for Medicare reimbursement of home health services. Special instructions 1. The client must be confined to the home or place of residence that is not a hospital or skilled nursing facility [Homebound]. The client may leave their home for medical appointments and treatments without compromising home bound status. Attendance at adult day care does not preclude the client from receiving Medicare home health services, if indicated. 2. The client must be under the care of a physician who establishes and reviews the Plan of Care. 3. The client must need at least one of the following skilled services as certified by the physician a. Intermittent skilled nursing b. Physical Therapy c. Speech Language Pathology d. Continuing Occupational Therapy if he prior need for skilled nursing, physical therapy, or</p>			

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	<p>speech therapy had been established in the current or prior certification period.</p> <p>4. The services required or anticipated coverage must meet part time or intermittent criteria. 5. The services must be reasonable and necessary as determined by the client condition, diagnosis, available caregivers, and documentation must also reflect that services meet this criteria."</p> <p>8. The undated agency policy titled "Client Admission Process" stated, "Special instructions 1. Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include a. The client / caregiver has an acceptance of home care b. The client / caregiver's ability and willingness to provide interim care, when necessary. c. The home environment is suitable or adaptable for proper home care. d. The client's needs can safely and adequately be met at the home. This includes the ongoing availability of personnel and equipment and a plan to meet medical emergencies ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine the eligibility for the Medicare home health benefit ... the admission professional will</p>			

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	<p>... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedure for filing a complaint. This includes the Statement of Privacy Rights related to the collection and transmission of personal health care information."</p> <p>9. The undated agency policy titled "Statement of Responsibility: Administrator" stated, "In compliance with established policy, and in the event that the administrator: [Employee H] is not available, the designated, qualified back up: [Employee G] will assume the duties of administrator ... The administrator and designated back up shall comply with accepted professional standards and principles that apply to professionals providing home care services." This was signed by Employee G and Employee H on 4/5/17.</p> <p>10. The undated agency policy titled "Services Provided" stated, "Agency will also provide Physical, Occupational, and Speech Therapy on a visiting basis to clients in their place of residence."</p> <p>11. The undated agency policy titled "Admission Process" stated, "Clients are accepted for treatment in the home on the basis of reasonable criteria and under the</p>			

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	<p>expectation that the client's medical, nursing, and social needs can be met adequately by agency in the client's place of residence."</p> <p>12. A review of a document titled "Position: Administrator" signed by the pending administrator and dated 6/16/17 stated, "Position Summary Plans, develops, and directs the programs, services, activities and employees of the agency ... Essential functions ... plans, organizes and directs the agency ongoing functions. 3. Directs and coordinates the overall development and administration of the agency consistent with agency mission and available resources ... assures compliance with federal / state regulations governing home health care services." 13. During a home visit observation of a home health aide for patient #2, on 6-9-17 at 9:00 AM, patient #2 stated most of the agency provided physical therapy and occupational therapy visits had occurred on the 2nd floor therapy room, referred to as "the gym," rather than patient #2's place of residence on the 3rd floor.</p>			

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G 0139  Bldg. 00	<p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours. Based on record review and interview, the agency failed to ensure it appointed a qualified registered nurse for the alternate supervising nurse position for 1 of 1 agency.</p> <p>Findings include</p> <p>1. A review of the agency documents failed to evidence the appointment of a qualified alternate nursing supervisor after the resignation of Employee AA, resignation 4/14/17. The agency had documentation for a pending candidate, Employee I, Registered Nurse. The dates of employment evidenced on the resume did not correspond to dates of employment evidenced below (see #5 ). A job description obtained from a previous employer failed to evidence supervisory experience needed for the position found below (see finding #9).</p> <p>2. During an interview on 6/9/17 at 11</p>	G 0139	<p>1)The administrator &amp; clinical manager/HR manager will review the hiring policies and procedures for compliance: A. The agency will initiate an outside source for verification of employment of all future applicants considered for open positions. B. Applicants will not be scheduled for orientation until the administrator has reviewed and approved an applicant for hire. 2) HR audits of new hires to be completed by the HR manager on 100% of all new hires. This is ongoing. 3) Administrator and HR Manager are responsible. 4) Date of Compliance is 08/18/17.</p>	08/18/2017	

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	<p>AM, the owner of the agency, Employee J, Physical Therapist indicated actively searching for a replacement for Employee AA since April 2017.</p> <p>A. A review of a screen shot from webmail showed email correspondence concerning RN Home Health Resumes from 4/21/17 - 5/31/17 from Employee J's email. This was presented on 6/9/17.</p> <p>3. A review of a letter addressed to the program director of the Indiana State Department of Health stated, "Re: Staff change for Priority Rehab Home Health DBA Back Home Again Facility License #17 - 003800 - 1 Dear [Program Director] I am writing on behalf of staff changes for Back Home Again. Enclosed are the staff change notification forms, resumes, and criminal history checks as well as any other supporting documentation ... [Employee I, RN] will be the alternate director of nursing pending approval." This was signed by the owner, Employee J, Physical Therapist.</p> <p>4. The undated job description "C-126 Position: Alternate Director of Nursing" stated, Minimum of 2 years experience in an acute hospital setting or equivalent experience with one year of supervisory experience."</p>			

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	<p>5. A review of the resume for Employee I failed to evidence accurate dates of employment with previous employers listed on Employee I's resume. This was evidenced by the following:</p> <p>A. A review of the undated resume of Employee I evidenced employment at the Indiana State Department of Health from September 2016 - March 2017 as a Registered Nurse. Also included on this resume were the dates of October 2014 - August 2016 as a Registered Nurse. The description of this position stated, "Supervise and educate teams, confirm and develop competency, supervise 2 - 3 Licensed Practical Nurses and 25 Home Health Aides ... Monitors on - going staff development programs for nursing personnel. Also included on this resume were the dates of August 2012 - October 2014 RN at a physician office. Also included on this resume were the dates of May 2009 - August 2012.</p> <p>B. A review of Indiana State Department of Health record evidenced the dates of employment for this employee were September 2016 - January 31, 2017. The resume evidenced Employee I had worked in this role from September 2016 - March 2016.</p>			

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	<p>C. A review of an application for employment document dated 4/10/17 evidenced Employee I applied for a position of Nursing Supervisor / Contract employee.</p> <p>D. A review of an interview review document dated 4/7/17 and completed by the owner, Employee J, a physical therapist, evidenced Employee I was a good candidate for employment.</p> <p>E. A review of an employment reference request completed by an unknown company and dated 4/13/17 evidenced Employee I had worked for this company from 5/2009 - 10/2011. The resume evidenced employment for a nurse position from May 2009 - August 2012.</p> <p>F. A review of an employee reference request completed by the current alternate administrator / director of nursing and dated 4/14/17 evidenced the employee had worked for this home health agency from 10/2014 - 8/2016. Below is a document from that agency:</p> <p>G. A review of a document from the other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate</p>				

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	<p>administrator / director of nursing] 9/30/15 - 11/23/15 DON [director of nursing]."</p> <p>6. During an interview on 6/19/17 at 10:05 AM, the alternate administrator / director of nursing indicated that Employee I was qualified for the position and that she had given one of the two references for Employee I. She indicated working at the other agency while Employee I was in a supervisory role at the agency. She stated, "I didn't call because I was the boss at [name of the other agency]." She indicated this followed this agency's policy on checking references and verifying employment dates. She did not indicate concern that the employment date on the other reference letter varied from Employee I 'S resume.</p> <p>7. During a phone interview with the administrator of the agency where Employee I had worked, the administrator of the other agency indicated that Employee I had worked at this agency from 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 and the alternate administrator / director of nursing had worked from September 30, 2015 - November 23, 2015 in the role of director of nursing.</p>			

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	<p>8. A review of a document from the other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate administrator / director of nursing] 9/30/15 - 11/23/15 DON [director of nursing]."</p> <p>9. A review of a document from the other home health agency titled "Job Description Title of Position: Community Health Registered Nurse Title of Immediate Supervisor: Director of Nursing ... Duties of Position To provide nursing care in accordance with the client's plan of care to include comprehensive health and psychosocial evaluation, monitoring the client's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care." This job description did not show Employee I had an administrative / supervisory role in the agency. This job description was signed and dated by Employee I on 10/23/14.</p> <p>10. The undated agency policy titled "Reference Checks" stated, "The agency verifies the employment history and performance of applicants who are finalists for jobs prior to extending an offer. When a college degree or</p>			

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	<p>certification is a requirement of the job, reference checks may include verification of educational achievement or certification. Reference check information is used by the hiring supervisor, along with other information gathered in the selection process, to make a hiring decision. Procedures The candidates must have completed an application form that contains a release allowing the agency to validate information contained on the application. A standard reference form should be used. At least two references should be obtained - no more than one of them from a family member. If the candidate refuses to allow reference checks or verification of employment, advise the applicant that she or he will no longer be considered for the position. If references are questionable, work with human resources to determine whether the candidate should be considered further."</p> <p>11. The undated agency policy titled "Standard Hiring Process" stated, "The agency will establish a standard hiring process to be used for all applicants. Purpose To ensure that the process will identify any problems with employees background. Process 1. Job application a. This is the first opportunity to screen the prospective employee b. Allows the employer to obtain basic information</p>			

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	<p>about educational and work experiences and is the starting point of the selection process. c. Application must have a statement that all information is true and correct. This is important if contradicting information is discovered at a later date.</p> <p>2. Interview a. Every qualified job applicant should be interviewed ... 3. Background check a. Prior to conducting any background check, the employer must have a signed authorization from the applicant. b. There are five kinds of background checks that employers can conduct to verify candidate meets the expectations. i. Reference check - to verify the information the employee has provided - should be done on all applicants. ii. Criminal Background check -requirement will vary by state laws ... iii. Credit check ... iv. Drug Test ... v. Social Media and Internet check - this check should be used with caution because the employer may discover information that should not be used as a basis in hiring such as disabilities or health issues ... c. Analyze red flags. i. Reference checks can validate dates of employment and titles that were provided. Inconsistencies that cannot be explained are a warning sign. ii. Interviews - applicant must be able to explain gaps in employment and why they left the previous jobs listed on the application or resume."</p>			

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G 0141  Bldg. 00	<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.</p> <p>Based on record review and interview, the agency failed to ensure it appointed a qualified registered nurse for the alternate supervising nurse position according to agency policy for 1 of 1 agency.</p> <p>Findings include</p> <p>1. A review of the agency documents failed to evidence the appointment of a qualified alternate nursing supervisor after the resignation of Employee AA, resignation 4/14/17. The agency had documentation for a pending candidate, Employee I, Registered Nurse. The dates of employment evidenced on the resume did not correspond to dates of employment evidenced below (see #5 ). A job description obtained from a previous employer failed to evidence supervisory experience needed for the position found below (see finding #9).</p>	G 0141	<p>1)The administrator &amp; clinical manager/HR manager will review the hiring policies and procedures for compliance: A. The agency will initiate an outside source for verification of employment of all future applicants considered for open positions. B. Applicants will not be scheduled for orientation until the administrator has reviewed and approved an applicant for hire. 2) HR audits of new hires to be completed by the HR manager on 100% of all new hires. This is ongoing. 3) Administrator &amp; HR manager are responsible. 4) Date of Compliance is 08/18/17.</p>	08/18/2017

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	<p>This evidenced below and includes interviews:</p> <p>2. During an interview on 6/9/17 at 11 AM, the owner of the agency, Employee J, Physical Therapist indicated actively searching for a replacement for Employee AA since April 2017.</p> <p>A review of a screen shot from webmail showed email correspondence concerning RN Home Health Resumes from 4/21/17 - 5/31/17 from Employee J's email. This was presented on 6/9/17.</p> <p>3. A review of a letter addressed to the program director of the Indiana State Department of Health stated, "Re: Staff change for Priority Rehab Home Health DBA Back Home Again Facility License #17 - 003800 - 1 Dear [Program Director] I am writing on behalf of staff changes for Back Home Again. Enclosed are the staff change notification forms, resumes, and criminal history checks as well as any other supporting documentation ... [Employee I, RN] will be the alternate director of nursing pending approval." This was signed by the owner, Employee J, Physical Therapist.</p> <p>4. The undated job description "C-126 Position: Alternate Director of Nursing"</p>						

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	<p>stated, Minimum of 2 years experience in an acute hospital setting or equivalent experience with one year of supervisory experience."</p> <p>5. A review of the resume for Employee I failed to evidence accurate dates of employment with previous employers listed on Employee I 's resume. This is evidenced by the following:</p> <p>A. A review of the undated resume of Employee I evidenced employment at the Indiana State Department of Health from September 2016 - March 2017 as a Registered Nurse. Also included on this resume were the dates of October 2014 - August 2016 as a Registered Nurse. The description of this position stated, "Supervise and educate teams, confirm and develop competency, supervise 2 - 3 Licensed Practical Nurses and 25 Home Health Aides ... Monitors on - going staff development programs for nursing personnel. Also included on this resume were the dates of August 2012 - October 2014 RN at a physician office. Also included on this resume were the dates of May 2009 - August 2012.</p> <p>B. A review of Indiana State Department of Health record evidenced the dates of employment for this employee were September 2016 - January</p>			

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	<p>31, 2017. The resume evidenced Employee I had worked in this role from September 2016 - March 2016.</p> <p>C. A review of an application for employment document dated 4/10/17 evidenced Employee I applied for a position of Nursing Supervisor / Contract employee.</p> <p>D. A review of an interview review document dated 4/7/17 and completed by the owner, Employee J, a physical therapist, evidenced Employee I was a good candidate for employment.</p> <p>E. A review of an employment reference request completed by an unknown company and dated 4/13/17 evidenced Employee I had worked for this company from 5/2009 - 10/2011. The resume evidenced employment for a nurse position from May 2009 - August 2012.</p> <p>F. A review of an employee reference request completed by the current alternate administrator / director of nursing and dated 4/14/17 evidenced the employee had worked for this home health agency from 10/2014 - 8/2016. Below is a document from that agency:</p> <p>G. A review of a document from the</p>						

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	<p>other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate administrator / director of nursing] 9/30/15 - 11/23/15 DON [director of nursing]."</p> <p>6. During an interview on 6/19/17 at 10:05 AM, the alternate administrator / director of nursing indicated that Employee I was qualified for the position and that she had given one of the two references for Employee I. She indicated working at the other agency while Employee I was in a supervisory role at the agency. She stated, "I didn't call because I was the boss at [name of the other agency]." She indicated this followed this agency's policy on checking references and verifying employment dates. She did not indicate concern that the employment date on the other reference letter varied from Employee I's resume.</p> <p>7. During a phone interview with the administrator of the agency where Employee I had worked, the administrator of the other agency indicated that Employee I had worked at this agency from 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 and the alternate</p>			

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	<p>administrator / director of nursing had worked from September 30, 2015 - November 23, 2015 in the role of director of nursing.</p> <p>8. A review of a document from the other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate administrator / director of nursing] 9/30/15 - 11/23/15 DON."</p> <p>9. A review of a document from the other home health agency titled "Job Description Title of Position: Community Health Registered Nurse Title of Immediate Supervisor: Director of Nursing ... Duties of Position To provide nursing care in accordance with the client's plan of care to include comprehensive health and psychosocial evaluation, monitoring the client's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care." This job description did not show Employee I had an administrative / supervisory role in the agency. This job description was signed and dated by Employee I on 10/23/14.</p> <p>10. The undated agency policy titled "Reference Checks" stated, "The agency</p>			

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	<p>verifies the employment history and performance of applicants who are finalists for jobs prior to extending an offer. When a college degree or certification is a requirement of the job, reference checks may include verification of educational achievement or certification. Reference check information is used by the hiring supervisor, along with other information gathered in the selection process, to make a hiring decision. Procedures The candidates must have completed an application form that contains a release allowing the agency to validate information contained on the application. A standard reference form should be used. At least two references should be obtained - no more than one of them from a family member. If the candidate refuses to allow reference checks or verification of employment, advise the applicant that she or he will no longer be considered for the position. If references are questionable, work with human resources to determine whether the candidate should be considered further."</p> <p>11. The undated agency policy titled "Standard Hiring Process" stated, "The agency will establish a standard hiring process to be used for all applicants. Purpose To ensure that the process will identify any problems with employees</p>			

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	<p>background. Process 1. Job application</p> <p>a. This is the first opportunity to screen the prospective employee b. Allows the employer to obtain basic information about educational and work experiences and is the starting point of the selection process. c. Application must have a statement that all information is true and correct. This is important if contradicting information is discovered at a later date.</p> <p>2. Interview a. Every qualified job applicant should be interviewed ... 3. Background check a. Prior to conducting any background check, the employer must have a signed authorization from the applicant. b. There are five kinds of background checks that employers can conduct to verify candidate meets the expectations. i. Reference check - to verify the information the employee has provided - should be done on all applicants. ii. Criminal Background check -requirement will vary by state laws ... iii. Credit check ... iv. Drug Test ... v. Social Media and Internet check - this check should be used with caution because the employer may discover information that should not be used as a basis in hiring such as disabilities or health issues ... c. Analyze red flags. i. Reference checks can validate dates of employment and titles that were provided. Inconsistencies that cannot be explained are a warning sign. ii.</p>			

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G 0156 Bldg. 00	<p>Interviews - applicant must be able to explain gaps in employment and why they left the previous jobs listed on the application or resume."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patient needs were addressed and being met adequately in the patient's place of residence for 1 of 12 records reviewed (see G 157); failed to ensure plans of care were complete and accurate and signed by the physician in a timely manner for 2 of 12 records reviewed (see G 159); and failed to ensure the physicians' verbal, telephone, and plan of care orders were put into writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services for 4 of 12 records reviewed (see G 166).</p> <p>The cumulative effect of these systemic</p>	G 0156	<p>1. The agency will only accept patients when the patients' health needs can be adequately met by the home health agency in the patients place of residence. If the established plan of care is ineffective and not met within the agencies parameters a referral will be made to an alternate provider.</p> <p>A. All staff to receive reeducation of home health admission/CMS standards and coordination of care with documentation between team members, physicians and outside facilities if a patient is transferred out of care.</p> <p>B. All direct care staff to receive education and training on patient medical plan of care, pain management with documentation and coordination of services as well as medication management with documentation and</p>	08/04/2017

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G 0157  Bldg. 00	<p>problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on home visit observation, record review and interview, the agency failed to ensure patient needs were addressed and</p>	G 0157	<p>coordination of services. C. All direct care staff to receive education and training on patient safety as well as identification to prevent potential adverse events. 2 2) The Clinical Manager will include A, B &amp; C in new employee orientation as well as annually for all direct care staff. HR charts audited for compliance annually with review and remediated for 100% compliance within 30 days of annual review. 100% of patient records admitted after 08/04/17 will be audited x3months &amp; then 10% quarterly for coordination of care, pain management, making changes to the POC for patient changes in condition and identifying adverse events. These will be documented quarterly. Should errors continue staff will be counseled. 3 3) Administrator and Clinical Manager (DON) are responsible. 4) Date of compliance to be 08/04/17.</p> <p>1. 1. The agency will only accept patients when the patients' health needs can be adequately met by the home health agency in</p>	08/04/2017	

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	<p>being met adequately in the patient's place of residence for 1 of 12 records reviewed (#3).</p> <p>The findings include:</p> <p>1. A review of Clinical record #3, start of care 3/6/17, failed to evidence the patient's needs were met. The patient had ongoing severe pain issues and constipation issues since a fall documented 5/26/17 with T 12 compression fracture diagnosis after an emergency room visit. The patient's record included a "Home Health Certification and Plan of care" dated 5/4/17 and signed by the physician on 5/22/17. The patient was being seen by the Skilled Nurse for ongoing education on disease processes and medications. Physical and occupational therapy for lower extremity strengthening, transfer training and standing balance. The patient made plans to discharge from the agency on 6/15/17 and transfer to a rehabilitation skilled facility due to the ongoing pain concerns. There was no detailed communication showing discussion between the physician, physical therapist, skilled nurse, and occupational therapy about what medications the patient was taking and if any relief was occurring with specific pain medications or a plan to manage this</p>		<p>the patients place of residence. If the established plan of care is ineffective and not met within the agencies parameters a referral will be made to an alternate provider.</p> <p>A. All staff to receive reeducation of home health admission/CMS standards and coordination of care with documentation between team members, physicians and outside facilities if a patient is transferred out of care.</p> <p>B. All direct care staff to receive education and training on patient medical plan of care, pain management with documentation and coordination of services as well as medication management with documentation and coordination of services.</p> <p>C. All direct care staff to receive education and training on patient safety as well as identification to prevent potential adverse events.</p> <p>2. The Clinical Manager will include A, B &amp; C in new employee orientation as well as annually for all direct care staff. HR charts audited for compliance annually with review and remediated for 100% compliance within 30 days of annual review. 100% of patient records admitted after 08/04/17 will be audited x3months for coordination of care, pain management, making changes to the POC for patient changes in condition and identifying adverse events. These will be documented quarterly. Should</p>	

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	<p>severe pain. The plan of care and updates to the plan of care were not updated to show a pain management plan on the plan of care. This is evidenced by the following:</p> <p>A. A review of a 5/26/17 RN - Skilled Nursing (SN) Visit- completed by Employee B, Registered Nurse, evidenced communication between the occupational therapist and RN that the patient had fallen in the past week. The SN documented that reviewing all body systems of the patient, that the patient's pain level was a "5" on a 10 point scale with "10" being severe pain and "0" being no pain. The skilled nurse documented that the patient was taking Tylenol which had fair results.</p> <p>B. A review of an emergency room discharge disposition evidenced the patient was treated in the emergency room for a compression fracture. This was dated 5/27/17.</p> <p>C. A review of a PT re - evaluation visit completed by Employee B, PT, dated 5/30/17 evidenced patient reported a fall and complaint of lower back pain since that fall.</p> <p>D. A review of a OT Re- evaluation visit completed by Employee D, OT, and</p>		<p>errors continue staff will be counseled.</p> <p>3. Administrator and Clinical Manager (DON) are responsible.</p> <p>4. Date of compliance to be 08/04/17.</p>		

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	<p>dated 5/30/17 evidenced this statement: "Pt reports falling within past week. Pt was taken to hospital c /o lower back pain however no major injury."</p> <p>E. A review of a 6/1/17 note titled "OASIS C2 Transfer" evidenced the patient had transferred to an inpatient facility due to injury caused by fall. The transfer had occurred on 5/31/17. This document was completed by Employee B.</p> <p>F. A review of a procedure dictation document for a procedure 5/31/17 evidenced the patient had a T 12 compression fracture. The patient had lidocaine patches to apply. The patient reported increasing pain at a "9 - 10" level.</p> <p>G. A review of the record evidenced a resumption of care assessment dated 6/5/17 after a patient's return from an inpatient hospital stay. The pain portion of this assessment evidenced the patient's pain was a level 8 with constant duration with throbbing quality and any movement makes the pain worse. What makes pain better is medication, relaxation, decreased movement. The medications weren't documented and the patient's pain goal was not documented. There were no goals documented for decreased pain.</p>			

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	<p>This document stated, "had fall while out of town, returned home then went to ED [emergency department] for worsening pain. It was determined [patient] had fx at T 12. Physician has been notified of initial assessment and tentative POC [plan of care], frequency, interventions, and goals to be documented on 485 [plan of care] and submitted for signature. Patient is agreeable to proposed POC."</p> <p>During an interview on 6/19/17 at 2:50 PM, the director of nursing indicated the resumption was late because they were not notified of the patient's return home from the hospital.</p> <p>H. A review of the medication profile dated 6/5/17 evidenced colace for constipation and no other medication to relieve constipation. Tramadol HCL oral 50 milligrams 1 tablet twice a day was ordered for pain. There were no other pain medications ordered including Tylenol except Aspirin oral 81 mg 1 tablet daily analgesics.</p> <p>I. A review of a PT (physical therapy) evaluation visit document dated 6/6/17 signed by Employee A, Physical Therapist evidenced the patient had complained of severe pain at a level of "10" (with "0" being no pain and "10" being the most severe.) This evaluation</p>			

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	<p>failed to evidence a complete pain assessment. There was no description of the pain with this assessment. This document evidenced that the factor contributing functional impairment was weakness and back pain. The treatment goal was for the patient to report that back pain does not limit [his / her] ability to walk from apartment to facility dining room.</p> <p>J. A review of an OT (occupational therapy) Re-evaluation Visit document dated 6/6/17 signed by Employee D, OT evidenced the patient had complained of severe pain at a level of 10. There was no description of the pain with this assessment. The evaluation assessment summary stated, "Due to increased back pain, patient reports not leaving room for last few days for meals / going out. Pt is requiring significantly increased assistance with all self care and functional mobility tasks due to severe back pain. Pt. recently received orders from physician to wear back brace while up. Pt. requires maximum assist to don supportive back brace. Due to physical / cognitive deficits, pt's [informal caregiver] is unable to safely and accurately assist with back brace. Pt will benefit from continued OT focusing on increasing BUE [bilateral upper extremity] strength, activity tolerance,</p>			

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	<p>improving self - regulation of pain from arthritis symptoms and increasing functional transfers in order to maximum safety and independence with daily routine and functional mobility tasks."</p> <p>K. A review of the record evidenced a skilled nursing visit dated 6/7/17 signed by Employee B. The nurse documented the patient's pain level was a "6". There was also a note: "Doctor was called about pt. has been sitting in chair since Sunday and has ate / drank little, has moved infrequently, and is taking pain medication tramadol. Instructed pt on constipation prevention, hydration, movement, use of colace as ordered regularly. SN called [informal caregiver] to see what prn [as needed] medications are available to patient, instructed [informal caregiver] on constipation and pain medications effects on constipation ... called [informal caregiver] who sets up meds to see if patient had prn miralax or milk of magnesia." The physician was contacted about severe pain but not about the constipation. There were no communications with the physician confirming that the patient had prn miralax or milk of magnesia to help with the constipation. There were no communications in the record about what the physician communicated about the severe pain to this nurse. The time in</p>				

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	<p>was 10:15 AM and time out 10:46 AM.</p> <p>L. A review of a PTA visit dated 6/7/17 evidenced a therapy assistant visit signed by Employee C. The time in for this visit was 10:48 AM. Time out was 11:22 AM.</p> <p>M. A review of the record evidenced a skilled nursing visit dated 6/8/17 signed by Employee B. Patient had a small bowel movement evening before. Pain level was a "9" at this visit. The physician was not notified.</p> <p>N. A review of the record evidenced a COTA visit signed by Employee E, COTA. The pain level was not described or a severity level given. The pain was located in the lower back.</p> <p>O. A review of the record evidenced an OT visit signed by Employee D, OT. The pain level was not described or a severity level given. The pain was located in the lower back.</p> <p>P. A review of a PTA visit dated 6/9/17 evidenced a therapy assistant visit signed by Employee C.</p> <p>Q. A review of the record evidenced a PTA visit signed by Employee C, PTA</p>			

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	<p>dated 6/12/17 with patient complaints of severe pain at a "9" level. This visit was communicated with Employee A, Employee B, and Employee D. The physician was not contacted.</p> <p>R. A review of the record evidenced a OT visit signed by employee D, OT, on 6/12/17. The patient's pain was located in the lower back but not described further.</p> <p>S. A review of the record evidenced a RN - Skilled Nursing Visit completed by Employee B, RN on 6/12/17 The patient had a pain level of a 10. This document was missing pages 3 and 4.</p> <p>T. A review of the record evidenced a physical therapy visit dated 6/13/17 signed by Employee A. The physical therapist documented that the patient complained of severe pain at a "11" on the "10 point scale with no relief and constipation. Physician was called with update and voicemail left. There was no communication noted with the physician at this time. Another note with this date signed by Employee A evidenced the patient had stated he / she would end his / her life because the pain was so severe.</p> <p>At a home visit observation on 6/13/17 at 9:05 AM with patient #3 and</p>				

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	<p>Employee A, physical therapist, patient #3 was observed to ambulate from the bathroom to a chair in the living room. Patient #3 was observed to complain of severe pain and lack of appetite and food intake and constipation with lack of bowel movement for 4 days. Patient #3 indicated taking pills at 8 AM including the pain medication, Tramadol. The patient indicated the pain was at a level of a "11" on a 10 point scale with no pain relief from the tramadol. Employee A asked the patient about the pain level. Employee A did not ask the patient to describe the pain. The PT took the patient's vital signs and continued with the therapy exercises including marching in place in a seated position. At 9:32 AM, Employee A was observed to leave a voice mail on the physician's phone. Employee A asked about the patient's pain level three times through the visit and the patient answered the pain was at a level of "11" each time. These questions were asked at the beginning of the visit, the middle of the visit, and at the end of the visit. The patient answered that the pain was so severe that he / she wished to end his / her life. The patient asked at the end of the visit, "What am I going to do about this pain?" The physical therapist said to take an ice pack and use it off and on about 20 minutes at a time for pain relief. The PT, Employee</p>			

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	<p>A stated, "Keep a good attitude and stay positive."</p> <p>U. A review of the patient communication note dated 6/13/17 signed by Employee E, Certified Occupational Therapy Assistant, evidenced that a canceled visit due to the patient's pain level.</p> <p>V. A review of the record evidenced the physician returned a call to the PT, Employee A, and acknowledged receipt of message about the patient's pain and that the physician is in contact with the family. This was dated and signed on 6/14/17.</p> <p>X. A review of the record evidenced a PTA (physical therapy assistant) visit dated 6/14/17 with the patient's continued report of pain of a 9 level. Exercises included hip flexion and extensions, hip abductions and adductions, internal rotation, external rotation, and knee flexions and extensions.</p> <p>Y. A review of the record evidenced a patient communication note signed by Employee A that the informal caregiver called to cancel PT / OT visits today since patient is anticipating moving to a rehab today. PT and OT were notified. This was dated 6/15/17.</p>			

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	<p>2. The undated agency policy titled "Client Admission Process" stated, "All services are available without distinction to all individuals, regardless of their diagnosis ... The agency determines that client needs can be met by the agency."</p> <p>3. The undated agency policy titled "Pain Assessment / Management" stated, "All clients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as treatment of efficacy of treatment. The agency will work with the client, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will be reviewed and modified if the client does not have pain relief. Poorly managed pain delays healing and recover time, alters the body's immune system and increases stress, anxiety and depression. Clients will be informed that they have the right to have pain evaluated and effectively treated. Pain will be treated as a vital sign and agency will strive to ensure that pain is measured and treated .... Pain assessment is an integral part of the initial comprehensive assessment and the client's right to expect appropriate assessment and management</p>			

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	<p>is explained and honored. If the client has pain that interferes with pain or movement on a daily basis or is determined to be intractable, pain management will be specified intervention on the plan of care ... Pain is assessed on every nurse / therapist home visit and documented on a pain or symptom flow sheet. Documentation will include the effectiveness of all pain interventions or modalities. The documentation will include what interventions were used and describe response / effectiveness of care. 4. Referrals to pain specialist and utilization of best practices will be documented if utilized. 5. The nurse / therapist will use a standardized agency accepted pain assessment tool that evaluates the locations, duration, severity [rating scale], alleviating factors, exacerbating factors, current treatment [medication and non-medication] and response to treatment. 6. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral or alternative therapy. If the established plan is ineffective and the pain management needs can not be met within the agency pain parameters, a referral will be made to an alternate provider. 7. Assessment of presence of pain and treatment / response will be incorporated into all</p>			

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G 0159  Bldg. 00	<p>agency assessment / reassessment tools."</p> <p>4. During an interview on 6/19/17 at 3:10 PM, the director of nursing stated, "We can only do what we can do."</p> <p>5. During an interview on 6/19/17 at 5:30 PM, the pending administrator indicated that the plan was to be there with patient's pain. A patient's pain level is subjective and physical therapy was the plan for pain management.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review and interview, the agency failed to ensure plans of care</p>	G 0159	1) The medical plan of care shall be developed in	08/04/2017	

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	<p>were complete and accurate and signed by the physician in a timely manner for 2 of 12 records reviewed (#3, #8).</p> <p>The findings include:</p> <p>1. A review of clinical record #3 included a document titled "Home Health Certification and Plan of care" for the certification period of 5/5/17 - 7/3/17. This plan of care had been signed by the Registered Nurse, Employee B, on 5/4/17 and the physician on 5/22/17. The plan of care included orders for the skilled nurse to be seen 1 times a week for 3 weeks. The plan of care stated, "[Patient's name] is being seen by SN for ongoing education on disease processes and medications. The statement on the plan of care did not indicated the specifics of what disease processes would be educated on.</p> <p>During an interview on 6/15/17 at 3:33 PM, the director of nursing indicated that this is a concern and is being addressed.</p> <p>2. A review of clinical record #8 with a start of care date of 6/2/17 included a "Home health Certification and Plan of Care" for the certification period of 6/8/17 - 8/6/17. This plan of care evidenced the nurse was to assess if the</p>		<p>consultation with all home health agency staff &amp; the physician to include all services to be provided, cover all pertinent diagnosis, and include key elements specific to the patient. The agency will immediately ensure it has physicians' verbal, telephone and plan of care orders put into writing and signed with the date &amp; time of receipt by the registered nurse or qualified therapist as required by 484.18(a). A. All clinical staff involved in the assessment, evaluation and development of a medical plan of care will be educated on all required elements specific to the patient. These will include mental status, types of services and equipment required, frequency and duration, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, safety measures, instructions for discharge or referral and therapy</p>	

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	<p>patient was filling the medication box to determine if patient is preparing correctly. This was not an accurate task for this plan of care. The patient's informal caregiver was filling the medication box and was not at the skilled nurse visit observed. The plan of care was not individualized for this patient. This is further evidenced by the following:</p> <p>A. During a home visit observation on 6/14/17 at 3:10 PM, Employee B was not observed to check if the patient was preparing the medication box. Employee B did not have a copy of the plan of care at the visit.</p> <p>B. During an interview on 6/14/17 at 3:30 PM, patient #8 indicated the informal caregiver was in charge of setting up the patient's medications weekly.</p> <p>C. During an interview on 6/16/17 at 3:20 PM, Employee I, RN, indicated that this task was not completed at the visit since this task was incorrectly listed on the plan of care.</p> <p>3. The undated agency policy titled "Plan of Care" stated, "Home care services are furnished under the direction of teh client's physician. The plan of care is</p>		<p>modalities. To ensure an individualized plan of care disease processes with patient education, medications, goals and interventions are to be incorporated.</p> <p>B. Staff to be educated on timely and accurate revisions to the plan of care and subsequent care coordination with team members and physicians.</p> <p>C. A copy of the current plan of care to be available in the patients' folder in the event that a clinician is unable to access their POC electronically.</p> <p>D. Before initiating services for a home health admission the Clinical Manager or alternate will verify that a qualified order for admission to services has been obtained and documented per CMS guidelines.</p> <p>E. All direct care staff will receive re-education on obtaining and documentation of physician orders.</p> <p>F. All office staff will receive re-education on</p>		

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G 0166 Bldg. 00	<p>based on a comprehensive assessment and information provided by the client / family and health team members ... an individualized plan of care signed by a physician shall be required for each client receiving home health and personal care services. The plan of care shall be completed in full to include a. all pertinent diagnosis [es] ... b. mental status c. Type, frequency, and duration of all visits / services d. Specific procedures and modalities for therapy services ... l. Medications, treatments, and procedures."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, the agency failed to ensure the physicians' verbal, telephone, and plan of care orders</p>	G 0166	<p>internal processing within the EMR to ensure orders are entered correctly and tracking appropriately 2) 100% of all new patient records will be audited for A-F at admission and recertification for accuracy, timely revisions and coordination of care for 3 months and then 10% quarterly. Clinical Manager or alternate to audit start of care for compliance content for item D-F on 100% of new SOC. Should errors continue, staff will be counseled. 3) Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance 08/04/17.</p> <p>1) The agency will immediately ensure they have physicians' verbal,</p>	08/04/2017	

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	<p>were put into writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services for 4 of 12 records reviewed (#1, #2, #4, #6).</p> <p>The findings include:</p> <p>1. A review of clinical record #1 failed to evidence signed physician start of care orders for skilled nursing to see this patient for home health services. This was evidenced as follows:</p> <p>A. A document identified as a prescription dated 5/8/17 and signed by the physician evidenced the following statement: Physical Therapy consult and treat. DX [diagnosis] generalized deconditioning right shoulder pain." This fax had been sent to the independent living via fax on 5/11/17. There was no documentation showing that home health, occupational therapy, or skilled nursing was ordered.</p> <p>B. A review of a document titled "A physician order for start of care" with patient #1's name on it and the signature of Employee A, physical therapist. This order with for Physical Therapy evaluation and treatment and Occupational Therapy evaluation and</p>		<p>telephone and plan of care orders put into writing and signed with the date &amp; time of receipt by the registered nurse or qualified therapist.</p> <p>A. Before initiating services for a home health admission the Clinical Manager or alternate will verify that a qualified order for admission to services has been obtained and documented per CMS guidelines.</p> <p>B. All direct care staff will receive re-education on obtaining and documentation of physician orders.</p> <p>C. All office staff will receive re-education on internal processing within the EMR to ensure orders are entered correctly and tracking appropriately.</p> <p>2) The Clinical Manager will audit all orders of 100% of new patient admitted after 8/04/17 for compliance x3 months and then 10% quarterly.</p> <p>3) The Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is</p>	

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	<p>treat. There was no inclusion of skilled nursing and the physician had not signed this order.</p> <p>C. A review of the record evidenced a start of care assessment visit titled "OASIS C2 Start of Care" dated 5/22/17 and completed by the registered nurses: Director of Nursing and Employee B, RN.</p> <p>D. During an interview on 6/19/17 at 10:25 AM, the director of nursing indicated the orders were not complete and failed to include a signed physician order for skilled nursing.</p> <p>2. A review of clinical record #2 with a start of care date of 2/16/17 evidenced a plan of care that was not completed and signed in a timely manner. There were three different plans of care all for the same certification period found in the clinical record. Each of these differed from the other plans of care for the same certification period. Two were signed by the registered nurse and physician on different dates. Medications varied on these documents. This was evidenced by the following:</p> <p>A. A review on 6/8/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification</p>		08/04/17				

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	<p>period of 4/17/17 - 6/15/17 evidenced a document that was signed by the Employee B, RN, and not signed by the physician. Employee B signed this document on 4/14/17. There was no hydrocodone on this plan of care. Orders included skilled nurse 1 times a week for 9 weeks and as needed for emergency assessment. Physical therapy 1 x 1 weeks and 3 X 6 weeks. Occupational therapy 1 -2 week X 5 weeks and 1 X 4 weeks. Home health aide services 2 times a week for 9 weeks. This plan of care was not signed by the physician when reviewed on 6/8/17.</p> <p>i. During an interview on 6/8/17 at 4 PM, Employee I, RN, indicated the plan of care had not been signed by the physician.</p> <p>B. A review on 6/9/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced an incomplete document that had been signed by the physician on 4/25/17 and the nurse, Employee B, Registered Nurse, on 4/17/17. This document was not complete. This plan of care failed to give the patient's complete address, a principal diagnosis, and nutritional requirements. The medications on this plan of care included hydrocodone / acetaminophen</p>			

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	<p>by mouth tablet 5 - 325 milligrams 2 tablets every 6 hours.</p> <p>C. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a Home Health Certification and Plan of care with a certification period of 4/17/17 - 6/15/17 signed by Employee B, RN, on 4/14/17 and the physician on 5/23/17. This is not a timely physician signature. This was reviewed on 6/9/17.</p> <p>i. During an interview on 6/9/17 at 9:10 AM, the director of nursing indicated the plan of care had been incomplete when it was sent to the physician and needed to be resent to the physician after it had been completed. She did not indicate how this occurred but did indicate this is why there was more than one plan of care for the same certification period.</p> <p>3. A review of clinical record #4 with a start of care date of 4/7/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p>A A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of</p>			

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	<p>4/7/17 - 6/5/17 evidenced a document that was signed by the Employee B, RN, and signed by the physician on 6/13/17. Employee B, RN, signed the verbal order start of care on 4/7/17.</p> <p>4. A review of clinical record #6 with a start of care date of 3/1/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/30/17 - 6/28/17 evidenced a document that was signed by the Employee B, RN, and signed by the physician on 6/18/17. Employee B, RN, signed the verbal order start of care on 4/29/17.</p> <p style="padding-left: 40px;">B. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated the plan of care was not signed by the physician in a timely manner.</p> <p>5. The undated agency policy titled "Physician Orders" stated, "Policy All medications, treatments and services must be ordered by a physician. The orders may be initiated via telephone or in writing and be countersigned by the physician in a timely manner. Orders may be facsimile. Orders signed by the</p>			

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G 0171 Bldg. 00	<p>physician may be in writing or signed electronically. All medications and treatments, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by the licensed personnel designated by the agency in accordance with applicable state and federal law and organizational policy. Orders will be accepted only from physicians who have a current license in the state of operation."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on home visit observation, record review and interview, the agency failed to complete an accurate initial assessment to determine eligibility for the Medicare home health benefit including homebound status for 5 of 12 records reviewed (#1, #4, #5, #9, #11).</p> <p>The findings include:</p> <p>1. A review of Clinical record #1's record with a start of care (SOC) 5/22/17</p>	G 0171	<p><b>G171 Duties of the Registered Nurse</b> 1)The agency will immediately complete an accurate initial &amp; comprehensive assessment of all patients admitted for a home health episode. The agency will immediately evaluate the patients' nursing needs with an assessment each visit. This may include oasis</p>	08/04/2017	

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	<p>evidenced an incomplete and inaccurate initial assessment. The patient was able to complete ADLs (activities of daily living) independently and this assessment did not show that this could occur accurately. The assessment evidenced the patient had caregivers to help with these tasks but did not complete the section of supportive assistance who completed these tasks under M1100. The patient was not homebound. This patient had Medicare as a payor source. This was evidenced by the following:</p> <p>A. A review of Clinical record #1 failed to evidence a complete and accurate OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment. There were two of these documents dated 5/22/17. One was signed by the director of nursing and the other signed by Employee B, Registered Nurse and both of these were in the clinical record. This review occurred on 6/19/17. Both documents revealed the patient lives in a congregate situation. The section titled "M1100 ... Type of Assistance Receives - other than from home health agency staff was left blank. This included ADL (bathing, dressing, toileting, bowel / bladder, eating / feeding), IADLs (instrumental activities of daily living scale: meds, meals, housekeeping, laundry, telephone,</p>		<p>completion. Should a change in condition occur a comprehensive assessment will be done. Medicare patients not accepted for admission following initial assessment will receive the CMS NOMNC.</p> <p>A. All direct care staff (RN, PT, OT &amp; ST) will receive reeducation and training on completing an accurate initial patient assessment. Admitting professional shall document immediate care &amp; support needs and homebound status for Medicare. This includes skilled &amp; paraprofessional needs. This includes coordination of care with team members to identify discrepancies in clinical data and patient criteria for admission.</p> <p>B. The agency will contract an external QA (associated with the new EMR system) to evaluate all comprehensive assessments completed by SN, PT, OT, ST of the Oasis to monitor for discrepancies and contraindications. Final</p>		

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	shopping, finances), psychosocial support, assistance with medical appointments, delivery of medications, and management of finances). Under this was the name of Supportive assistance: Names of organizations providing assistance. This was left blank. Under the home bound section, a box was checked "Yes." Under this was checked a box titled "Residual weakness" and "Requires Max assistance / taxing effort to leave home and "Unable to safely leave home unassisted." The box titled "M1810 Current Ability to dress upper body safely [with or without dressing aids] including undergarments, pullovers, front - opening shirts and blouses, managing zippers, buttons, and snaps ... able to dress upper body without assistance if clothing laid out or handed to the patient ... M 1820 Current ability to dress lower body safely [with or without dressing aids] including undergarments, slacks, socks, or nylons, shoes ... 2. Someone must help the patient put on undergarments, slacks, socks, or nylons, and shoes ... M 1830 Bathing Current ability to wash entire body safely ... able to bathe in shower or tub independently, including get in and out of tub / shower ... M 1840 Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode ... 1. When		review and submission to be approved by the Clinical Manger or alternate; this includes the built in Oasis check included in the EMR prior to locking the Oasis. All modifications to the original submission to be documented on a modification revision form, signed by all parties, and incorporated into the patients' chart.  C. All RN's will receive reeducation and training on completing comprehensive assessments with SOC, ROC or regularly scheduled visits and documentation of findings. After the initial assessment, the admitting Registered Nurse/Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure:  i. Clarification of the plan of care orders.  ii. Client is able to receive safe and appropriate care in his/her place of residence.  iii. Client's homebound status for Medicare clients.  iv. Client's	

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	<p>reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer ... Transferring ... 2. Able to bear weight and pivot during the transfer process but unable to transfer self ... GG0170C Mobility Code the patient's usual performance at the SOC / ROC using the 6 point scale ... Coding: Safety and Quality of Performance ... 03 ... Partial or moderate assistance - helper does less than half the effort. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort ... M 1860 Ambulation / location ... able to walk only with the supervision or assistance of another person at all times ... M 2020 Management of Oral Medication ... Unable to take medication unless administered by another person ... M 2102 Types and sources of assistance ... Type of assistance ADL assistance [for example, transfer, ambulation, bathing, dressing, toileting, eating / feeding) ... non- agency caregivers currently providing assistance." Also marked in the 2102 box was that the IADLs assistance was completed with assistance, medication administered by a nonagency caregiver, supervision and safety. All of this assistance was provided at least daily. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task</p>		<p>need for skilled nursing care. v. Need for other services and/or referral to community resources. vi. Availability of caregivers or support system in the home setting. vii. Coordination with other agencies and institutions, if the need arises.</p> <p>D. All RN's will receive reeducation and training on case management, coordination of care and following patients in the hospital to reduce delay in Resumption of Care.</p> <p>E. The Clinical Manager will complete supervisory visits with field RN's quarterly to ensure complete assessments are completed on each visit. This will be ongoing. The agency will track patients transferred out and review patient pending status each weekday for obtaining prompt orders to complete ROC.</p> <p>2) Clinical Manager to audit and review the initial</p>	

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	<p>directions independently.</p> <p>B. A physical therapy (PT) evaluation visit completed on 5/22/17 at 3:38 PM evidenced the patient lived alone in a apartment in an independent living facility and has caregivers who assist with housekeeping and meal preparation. This was signed by Employee A, PT.</p> <p>C. A OT (occupational therapy) evaluation visit signed by Employee D, OT, dated 5/22/17 with a time of 2:50 PM stated, "Pt. ambulated with rolling walker and completed all ADL's and transfers with Mod [Modified] I / independently ... Pt. lives in ILF [independent living facility], pt's family lives nearby and able to assist with transportation, facility responsible for housekeeping and meal preparation ... Pt. lives in ILF, has shower chair with grab bars in WIS [walk in shower] and grab bars near toilet.</p> <p>C. A certified occupational therapy assistant visit dated 5/25/17 at 1 PM evidenced the patient is able to sit to stand with stand by assist. This was signed by Employee E, COTA.</p> <p>D. A physical therapy assistant (PTA) visit signed by Employee C and</p>		<p>assessment for required content and patient meeting the required elements for admission to home health prior to locking and approving the Oasis for submission to CMS. 100% of new admissions after 08/04/17 to be audited and then 10% quarterly.</p> <p>C. Clinical Manager will review reports from external QA before OASIS is submitted 100% of all new admissions for 3 months.</p> <p>D. This will be audited: 100% of all transferred patients x3 months &amp; then 10% quarterly.</p> <p>3) The Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/04/17</p>				

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	<p>dated 5/25/17 at 14:10 PM evidenced the patient was able to transfer from sit to stand and from stand to sit with stand by assist. There was no physical help given. The patient completed exercises on the Nu - Step machine.</p> <p>E. A physical therapy assistant visit signed by Employee C, PTA dated 6/1/17 at 13:36 PM evidenced the patient was able to transfer with sit / stand and stand / sit with stand by assist and was able to ambulate X 300 feet with rollator walker. The patient warmed up on a Nu - step machine at this visit.</p> <p>F. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care document evidenced a blank face to face encounter on 6/8/17 with no physician notes or encounter or signature.</p> <p>G. During an interview on 6/19/17 at 10:35 AM, the director of nursing indicated that this patient was homebound and caregivers provided care to the patient. She did indicate that the assessment was not completely filled out.</p> <p>H. During an interview with patient #1 on 6/19/17 at 12:10 PM, patient #1 indicated the ability to complete all activities of daily living independently</p>			

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	<p>including eating, dressing, toileting, transferring, transferring, and walking. She indicated that she was not homebound and was able to go out with friends and family to shop. She was able to walk to her physical therapy / occupational therapy in the rehab. room in the independent living without difficulty. She indicated she did not have caregivers help her with activities of daily living such as toileting, dressing, grooming, or bathing.</p> <p>2. A review of Clinical record #4's record included a start of care 4/21/17 and evidenced an incomplete and inaccurate initial assessment. The SN assessment in finding #A evidenced the patient was homebound and had a difficult time leaving the home. The PT and OT evaluations showed the patient was able to leave the apartment with a rolling walker. The patient had Medicare for the payor source. This was evidenced by the following:</p> <p>A. A review of a start of care "SN - Nursing C2 / ICD 10 v. 16.3" dated 4/7/17 and signed by Employee B, RN, on 4/21/17 evidenced an initial assessment that showed the patient was homebound and had a difficult and taxing effort to leave home and requires assist of 1 - 2 people. This document evidenced</p>			

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	<p>the patient was alert and oriented. This is not accurate as shown in finding #B - #D below:</p> <p>B. A review of a Physical Therapy evaluation signed by Employee A, physical therapist, dated 4/11/17 with a time in of 2:18 PM and time out of 3:04 PM stated that this patient uses rollater walker outside of apartment and lives in a independent living facility. The Tinetti Assessment completed on 4/11/17 was included in this evaluation visit and evidenced the patient was able to arise without using arms.</p> <p>C. A review of an Occupational Therapy Evaluation signed by Employee D, OT, dated 4/11/17 with a time in of 1:30 PM and time out of 2:11 PM evidenced the patient was able to complete bed mobility, toilet transfer, dynamic sitting balance, and static standing balance with stand by assist. A tub / shower assist and dynamic standing balance was completed by the patient with minimal assist. The patient is able to self feed and toilet with modified independent function. The patient is able to complete oral hygiene, groom, upper body bathing.</p> <p>D. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated</p>			

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	<p>being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>3. A review of Clinical record #5's record with a start of care 5/31/17 evidenced an incomplete and inaccurate initial assessment. The patient lived in an independent living facility and had no knowledge of receiving home health agency care. The patient's payer source was Medicare. This was evidenced by the following:</p> <p>A. A OASIS - C2 Start of care assessment document dated 5/31/17 and signed by Employee C, Registered Nurse, was not complete or accurate. The section titled "Type of Assistance Patient Receives" had not been completed including who provided ADL assist / bathing, dressing, toileting, bowel /</p>			

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	<p>bladder, eating / feeding.</p> <p>M 2012 The Types and Sources of Assistance evidenced that the patient had nonagency caregivers currently providing assistance with ADL's and that this assistance was provided 3 times a week or more. The M 1860 ambulation / locomotion section indicated the patient could only walk with the supervision or assistance of another person at all times. The GO170C mobility section evidenced the patient needed partial / moderate assistance: the helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort. This assessment also stated that the patient is able to bear weight and pivot with transfer process but unable to transfer self. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy evaluation signed by Employee A, PT, and dated 6/1/17 evidenced the patient lived in an independent living facility. Patient is oriented to person, place, time. Patient is able to sit to stand, stand to sit, and toilet with stand by assist.</p> <p>C. An OT evaluation dated 6/1/17 and signed by Employee D, OT, evidenced this patient lived in</p>				

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	<p>Independent Living facility. The patient is able to ambulate with assistive device and completed all ADL's and transfers with Modified Independent / Independently.</p> <p>D. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency. The patient indicated enjoying activities at the facility where he / she lived including dances and was able to participate in these dances.</p> <p>E. During an interview on 6/19/17 at 12 noon, the director of nursing and Employee I, RN, stated, "[He / she] has good days and bad days."</p> <p>F. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care" evidenced a blank face to face encounter on 6/15/17.</p> <p>8. A review of clinical record #9 with a start of care of 4/6/17 evidenced an incomplete and inaccurate initial assessment. The payer source is</p>				

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	<p>Medicare. This was evidenced by the following:</p> <p>A. A review of an OASIS - C2 Start of Care assessment completed on 4/6/17 with a signature of Employee K, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. Types and sources of assistance ADL assistance was checked that non - agency caregivers were currently providing assistance. M1810 and M 1820 evidenced the patient was able to dress self if clothes were laid or handed to patient. The mobility section numbered GG010C stated, "Safety and quality of performance - the patient needed supervision or touching assistance - helper sets up or cleans up and patient completes activity.</p> <p>B. A review of a occupational therapy evaluation dated 4/7/17 and signature of Employee D, OT, evidenced the patient was independent with bathing and dressing.</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated he / she was able to attend therapy sessions in the</p>			

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	<p>therapy room away from his / her apartment.</p> <p>D. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented time 3 (to person/place/time).</p> <p>9. A review of clinical record #11 with a start of care 5/24/17 evidenced an incomplete and inaccurate initial assessment. This patient lived alone and was able to complete ADLs independently. The payer source is Medicare. The initial assessment did not show that the patient had this level of independence. This was evidenced by the following:</p> <p>A. A review of an OASIS-C2 Start of Care assessment completed on 5/24/17 with a signature of Employee B, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. The M2102 Types and Sources of Assistance evidenced boxes checked that included the following: ADL assistance nonagency caregiver provide assistance, IADL assistance box checked that non-agency currently provide assistance,</p>			

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	<p>supervision and safety box was checked that non-agency caregiver provide assistance. These caregivers provided assistance one two times per week. The patient's mobility was shown as a 04 which meant that supervision or touching assistance was provided and a helper provides verbal cues or touching / steadying assistance as patient completes activity. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A review of an OT evaluation completed on 5/30/17 completed by Employee D, OT, evidenced patient could complete grooming with minimal assist, dress the lower body with minimal assist and toilet with supervision.</p> <p>C. During a home visit observation on 6/13/17 at 11:15 AM, patient #11 was observed to answer door independently and was able to transfer per self and ambulate per self.</p> <p>D. During a home visit observation interview on 6/13/17 at 12 noon, patient #11 indicated living alone in an independent living facility and being able to perform tasks like dressing independently.</p>			

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G 0172	<p>10. The undated agency policy titled "Clinical records / Medical Record Retention" stated, "Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members ... documentation shall reflect observations and should be objective and non- judgmental."</p> <p>11. The undated agency policy titled "Client Admission Process" stated, "Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine the eligibility for the Medicare Home Health benefit."</p> <p>12. During the entrance conference on 6/8/17 at 11 AM, the director of nursing indicated the initial and comprehensive assessments were combined in a start of care assessment and not usually completed separately but could be.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p>			

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Bldg. 00	<p>The registered nurse regularly re-evaluates the patients nursing needs. Based on observation, record review and interview, the Registered Nurse failed to re-evaluate a patient's nursing needs in relation to a foot assessment in 1 of 2 home visits observed with a Registered Nurse (patient #7 and Employee N, RN).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit observation on 6/12/17 at 2:15 PM, Employee N, Registered Nurse, was observed to complete a skilled nurse visit with patient #7. The nurse palpated the pedal pulse area of the patient's feet but did not pull of the patient's shoes and look at the entire feet.</li> <li>2. During an interview on 6/15/17, the director of nursing indicated the nurse did not look at the entire area of the feet.</li> <li>3. During a review of clinical record #7 and the document titled "Home Health Certification and Plan of Care" for the certification period of 5/14/17 - 7/12/17. This plan of care evidenced skilled nurse orders for 1 times a week for 9 weeks for assessment of patient.</li> </ol>	G 0172	<p>1) The agency will immediately reevaluate the patients' nursing needs with assessments each visit. This may include oasis completion.</p> <p>A. All RN's will receive reeducation and training on completing assessments with SOC, ROC or assessments at regularly scheduled visits and documentation of findings. Assessments will be based on patients' medical status, diagnosis, goals and outcomes anticipated.</p> <p>B. All RN's will receive reeducation and training on case management, coordination of care and following patients in the hospital to reduce delay in Resumption of Care.</p> <p>2) The Clinical Manager will complete supervisory visits with field RN's quarterly to ensure complete appropriate assessments are completed on each visit. This will be ongoing.</p>	08/04/2017			

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G 0186 Bldg. 00	<p>484.32 THERAPY SERVICES</p> <p>The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the physical therapist completed a complete pain assessment for 1 of 1 home visit observation (patient #3) of a physical therapist (Employee A) and failed to ensure the therapist (#A, # D) completed a complete pain assessment for 2 of 12 records reviewed of patients with therapy services (#3 and #4).</p> <p>The findings include:</p> <p>Regarding a home visit observation with patient #3 and Employee A, physical therapist</p> <p>1. At a home visit observation on 6/13/17 at 9:05 AM with patient #3 and Employee A, physical therapist, patient #3 was observed to ambulate from the bathroom to a chair in the living room. Patient #3 was observed to complain of severe pain and lack of appetite and food</p>	G 0186	<p>3) The Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/4/17.</p> <p>1) The appropriate therapist shall assist the physician or podiatrist in evaluating level of patient function by completing a complete assessment with each home visit.</p> <p>A. All therapists will receive education and training on patient medical plan of care with patient's medical doctor and other interdisciplinary team members and completing an evaluation of level of clinical condition and a function at each visit. Should pain be an identified problem, therapist will complete pain assessment each visit including documentation and management of the pain as well as coordination of care</p>	08/18/2017

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	<p>intake and constipation with lack of bowel movement for 4 days. Patient #3 indicated taking pills at 8 AM including the pain medication, Tramadol. The patient indicated the pain was at a level of a "11" on a 10 point scale with no pain relief from the tramadol. Employee A asked the patient about the pain level. Employee A did not ask the patient to describe the pain. The PT took the patient's vital signs and continued with the therapy exercises including marching in place in a seated position. At 9:32 AM, Employee A was observed to leave a voice mail on the physician's phone. Employee A asked about the patient's pain level three times through the visit and the patient answered the pain was at a level of "11" each time. These questions were asked at the beginning of the visit, the middle of the visit, and at the end of the visit. The patient answered that the pain was so severe that he / she wished to end his / her life. The patient asked at the end of the visit, "What am I going to do about this pain?" The physical therapist said to take an ice pack and use it off and on about 20 minutes at a time for pain relief. The PT, Employee A stated, "Keep a good attitude and stay positive."</p> <p>Regarding incomplete pain assessments for patient #3</p>		<p>with the patients' medical doctor.</p> <p>B. All therapists will receive education on identifying measurable treatment goals to ensure objective measurement of progress towards goals and / or therapy effectiveness.</p> <p>C. All therapists to be reeducated on notification to physician for any patient changes in condition.</p> <p>2) All therapy notes to be audited weekly for compliance for 3 month with 100% of current census and new admissions then 10% quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance 08/18/17.</p>	

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	<p>2. A review of an OT (occupational therapy) evaluation visit document dated 5/30/17 signed by Employee D, OT evidenced the patient had pain in bilateral hands and right knee. This pain was not described and no pain level was completed.</p> <p>3. A review of a PT (physical therapy) evaluation visit document dated 6/6/17 signed by Employee A, Physical Therapist evidenced the patient had complained of severe pain at a level of "10" (with "0" being no pain and "10" being the most severe pain. This evaluation failed to evidence a complete pain assessment. There was no description of the pain with this assessment. This document evidenced that the factor contributing to functional impairment was weakness and back pain. The treatment goal was for the patient to report that back pain does not limit [his / her] ability to walk from apartment to facility dining room.</p> <p>4. A review of an OT (occupational therapy) Re-evaluation Visit document dated 6/6/17 signed by Employee D, OT evidenced the patient had complained of severe pain at a level of 10. There was no description of the pain with this assessment. The evaluation assessment</p>			

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	<p>summary stated, "Due to increased back pain, patient reports not leaving room for last few days for meals / going out. Pt is requiring significantly increased assistance with all self care and functional mobility tasks due to severe back pain. Pt. recently received orders from physician to wear back brace while up. Pt. requires maximum assist to don supportive back brace. Due to physical / cognitive deficits, pt's [informal caregiver] is unable to safely and accurately assist with back brace. Pt will benefit from continued OT focusing on increasing BUE [bilateral upper extremity] strength, activity tolerance, improving self - regulation of pain from arthritis symptoms and increasing functional transfers in order to maximum safety and independence with daily routine and functional mobility tasks."</p> <p>5. A review of a PT evaluation visit documented dated 6/13/17 signed by Employee A evidenced the patient complained of severe pain at a level of "11" on a 10 point scale. There was no description of the pain with this assessment.</p> <p>Regarding incomplete pain assessment for patient #4</p> <p>6. A review of a physical therapy</p>			

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	<p>evaluation date of service 6/5/17 for a re-evaluation discharge visit completed by Employee A, PT, evidenced that the patient had a pain level of a "3" at this visit. The pain is located in the "tailbone." The pain quality was not described and details about the pain were not described such as what makes the pain worse.</p> <p>During an interview on 6/19/17 at 11:35 AM, the director of nursing indicated this assessment had not been completed.</p> <p>6. The undated agency policy titled "Pain Assessment / Management" stated, "All clients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as treatment of efficacy of treatment. The agency will work with the client, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will be reviewed and modified if the client does not have pain relief. Poorly managed pain delays healing and recover time, alters the body's immune system and increases stress, anxiety and depression. Clients will be informed that they have the right to have pain evaluated</p>			

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	and effectively treated. Pain will be treated as a vital sign and agency will strive to ensure that pain is measured and treated .... Pain assessment is an integral part of the initial comprehensive assessment and the client's right to expect appropriate assessment and management is explained and honored. If the client has pain that interferes with pain or movement on a daily basis or is determined to be intractable, pain management will be specified intervention on the plan of care ... Pain is assessed on every nurse / therapist home visit and documented on a pain or symptom flow sheet. Documentation will include the effectiveness of all pain interventions or modalities. The documentation will include what interventions were used and describe response / effectiveness of care. 4. Referrals to pain specialist and utilization of best practices will be documented if utilized. 5. The nurse / therapist will use a standardized agency accepted pain assessment tool that evaluates the locations, duration, severity [rating scale], alleviating factors, exacerbating factors, current treatment [medication and non-medication] and response to treatment. 6. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral or alternative			

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	<p>therapy. If the established plan is ineffective and the pain management needs can not be met within the agency pain parameters, a referral will be made to an alternate provider. 7. Assessment of presence of pain and treatment / response will be incorporated into all agency assessment / reassessment tools."</p> <p>7. During an interview on 6/19/17 at 3:10 PM, the director of nursing stated, "We can only do what we can do."</p> <p>8. During an interview on 6/19/17 at 5:30 PM, the pending administrator indicated that the plan is to be there with a patient's pain. A patient's pain level is subjective and physical therapy is the plan for pain management.</p> <p>9. The undated agency policy titled "Therapy Services" stated, "Measurable treatment goals be described in the plan of care and the patient's clinical record would demonstrate the method used to assess a patient's function would include objective measurement and successive comparison of measurements, thus enabling objective measurement or progress towards goals and / or therapy effectiveness."</p>			

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G 0235  Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>Based on home visit observation, record review and interview, it was determined the agency failed to ensure clinical records were maintained in accordance with professional standards and were complete and accurate for 8 of 12 clinical records reviewed (see G 236).</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment resulted in the agency being found out of compliance with this Condition of Participation 484.48 Medical Records.</p>	G 0235	<p>1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet the Condition of Participation 484.48 Medical Records. BHA's clinical record documentation process has been redeveloped as follows:</p> <p>A. Only one qualified professional will complete and sign and date the OASIS. If modifications are required to the OASIS, the reviewer will consult with the staff person who completes the OASIS who will then decide about any changes to be made. All changes to the OASIS will be documented as to what changes were made, who made the changes, and signed and dated by the professional completing the OASIS. This will be incorporated in the Medical Record. The OASIS Guidance Manual is a resource for the completion of the OASIS and a copy is in the office.</p> <p>B. The POC will be developed based on the patient's needs and in collaboration with the physician. The POC will include all the required data accurately documented including</p>	08/18/2017

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			<p>a complete and accurate medication list, frequency and duration of involved services, and signature and date of the Registered Nurse or Therapist responsible for the development of the POC. The POC will indicate the patient's individualized care plan specific to their assessed needs.</p> <p>C. The POC will be signed and dated by the physician in a timely manner, within 30 days, of the SOC, and documentation will evidence the return of the signed POC in a timely manner and tracking of the order and all attempts to have the POC returned signed in a timely manner.</p> <p>D. The Verbal SOC order will be documented and reflected on the POC with the RN or Therapists signature and date.</p> <p>E. This agency will complete an Initial Assessment/ Comprehensive Assessment in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or on the physician ordered SOC date. As stated in correction D above the Verbal SOC order will be documented and reflected on the POC &amp; in the patient record with the RN or Therapists signature and date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed</p>	

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			<p>needs. In addition, the Initial Assessment/ Comprehensive Assessment documentation will be completed timely. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures.</p> <p>F. The agency will complete a referral form upon receipt of the referral information. All information will be reviewed for completeness and identifying information prior to accepting the referral insuring that the referral is intended for home health not outpatient therapy. The agency referral form will be included in the medical record. All clinical staff (including Clinical Manager) as well as office staff that support the intake role will be educated and trained on these corrective measures.</p> <p>G. Any needed changes to a verbal order from its original form, will be documented in the medical record and the physician will be notified of the need to modify the order. The order will be sent to the physician for signature and date. The agency tracking process will apply. All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures to verbal orders.</p> <p>H. Any modifications/errors in documentation will be corrected according to the agency policy "Documentation of Changes to</p>	

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			<p>the Medical Record." All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures in documentation.</p> <p>I. The agency aide supervisory note will be accurately completed, dated and signed by the RN or Qualified Therapist and includes all the required documentation of the aide follows patient's plan of care, communicates openly with the patient, family, caregivers, respects the patients' rights, is competent to perform assigned tasks, complies with infections control measures, and appropriately reports any changes in the patient's condition. Documentation is specified to the patient's needs and response to services. The Clinical Manager will in-service RN, PT, OT staff on supervision of the aide and associated required documentation.</p> <p>J. An up-to-date master schedule and patient calendar will be maintained for each patient decreasing the risk of missed visits. A missed visit form will document the event of the missed visit, date, discipline, reason for missed visit, and how patient's needs were met. The physician will be notified of all missed visits and the master schedule and patient schedule will indicate missed visits.</p> <p>K. The agency will</p>	

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			<p>maintain the correct and current physician having oversight of the home health care admission in the medical record of patient services and care. The current and accurate physician will be notified in a timely manner of all incidents that affect and/or require modification to the POC. The agency will maintain the current and correct physician with contact information and all required information (i.e. NPI, PECOS, License, and confirmed by patient and physician). The Clinical Manager and all clinical staff to be reeducated and trained on these corrective measures.</p> <p>L. The agency will in-service all professional staff on the following agency policies:</p> <p>Physician Orders Medical Supervision Clinical Documentation Clinical Records/Medical Retention Documentation of Changes to the Medical Record</p> <p>The agency staff will sign a statement stating they understand these policies and agree to compliance with these policies. The signed statements will be included in the employees personnel file. Any contract staff will be included in the in-servicing process and will also sign the statement of understanding and compliance. The contract staff signed statement will be included</p>	

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			<p>in the contract file. Should errors continue staff will be counseled.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that all changes are noted in the medical recorded indicating who made the changes, what changes were made, signed and dated by the professional completing the OASIS; that all orders, including POC, are completed accurately; that the Initial Assessment / Comprehensive Assessment is completed within the regular time frames; that the referral form is completed accurately and that the referral is appropriate for the agency; that all changes to the medical record are compliant with the agency policy; that all changes to the medical record are compliant with agency policy.</p> <p>Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment / Comprehensive Assessment; that the referral process is completed accurately; that Oasis completion is accurate; that changes to the medical record are compliant; that aide supervisory visits are accurate and reflect individualized patient needs; that missed visits are recorded accurately; that the physician on record is accurate</p>	

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G 0236 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 home visit observation, record review and interview, the agency failed to ensure clinical records were maintained in accordance with professional standards and were complete and accurate for 8 of 12 clinical records reviewed (#1, #2, #3, #4, #5, #6, #8, #10).</p> <p>The findings include:</p> <p>1. A review of clinical record #1 failed to evidence a complete and accurate clinical record. The record had a Start of Care Assessment signed by two different nurses. This was evidenced as follows:</p>	G 0236	<p>and they are notified.</p> <p>3. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p> <p>4. Correction Date: 08/18/17</p> <p><b>G236 Clinical Records</b> 1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet the Condition of Participation 484.48 Medical Records. BHA's clinical record documentation process has been redeveloped as follows: A. Only one qualified professional will complete and sign and date the OASIS. If modifications are required to the OASIS, the reviewer will consult with the staff person who completes the OASIS who will then decide about any changes to</p>	08/18/2017

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	<p>A. A review of Clinical record #1 evidenced two OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment that were alike except having two different signatures from two different nurses. There were two of these documents dated 5/22/17 and completed at the start of care. One was signed by the director of nursing and the other signed by Employee B, Registered Nurse and both of these were in the clinical record. This review occurred on 6/19/17.</p> <p>B. During an interview on 6/19/17 at 10:45 AM, the director of nursing indicated signing the other nurse's document when she made spelling and grammatical errors. She indicated that this is a common practice at this agency when review of a clinical document occurs. She indicated using yellow sticky notes that would disappear after the review had occurred. Notations were not made that showed what changes had occurred or who had made these changes.</p> <p>2. A review of clinical record #2 with a start of care date of 2/16/17 evidenced a plan of care that was not completed and signed in a timely manner. There were three different plans of care all for the same certification period found in the clinical record. Each of these differed</p>		<p>be made. All changes to the OASIS will be documented as to what changes were made, who made the changes, and signed and dated by the professional completing the OASIS. This will be incorporated in the Medical Record. The OASIS Guidance Manual is a resource for the completion of the OASIS and a copy is in the office.</p> <p>B. The POC will be developed based on the patient's needs and in collaboration with the physician. The POC will include all the required data accurately documented including a complete and accurate medication list, frequency and duration of involved services, and signature and date of the Registered Nurse or Therapist responsible for the development of the POC. The POC will indicate the patient's individualized care plan specific to their assessed needs.</p> <p>C. The POC will be signed and dated by the physician in a timely manner, within 30 days, of the SOC, and documentation will evidence the return of the signed POC in a timely manner and tracking of the order and all attempts to have the POC returned signed in a timely manner.</p> <p>D. The Verbal SOC order will be documented and reflected on the POC with the RN or Therapists signature and date.</p> <p>E. This agency will</p>	

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	<p>from the other plans of care for the same certification period. Two were signed by the registered nurse and physician on different dates. Medications varied on these documents. This was evidenced by the following:</p> <p>A. A review on 6/8/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a document that was signed by the Employee B, RN, and not signed by the physician. Employee B signed this document on 4/14/17. There was no hydrocodone on this plan of care. Orders included skilled nurse 1 times a week for 9 weeks and as needed for emergency assessment. Physical therapy 1 x 1 weeks and 3 X 6 weeks. Occupational therapy 1 -2 week X 5 weeks and 1 X 4 weeks. Home health aide services 2 times a week for 9 weeks. This plan of care was not signed by the physician when reviewed on 6/8/17.</p> <p>i. During an interview on 6/8/17 at 4 PM, Employee I, RN, indicated the plan of care had not been signed by the physician.</p> <p>B. A review on 6/9/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification</p>		<p>complete an Initial Assessment, which may include a Comprehensive Assessment, in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or on the physician ordered SOC date. As stated in correction D above the Verbal SOC order will be documented and reflected on the POC &amp; in the patient record with the RN or Therapists signature and date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed needs. In addition, the Initial Assessment &amp; Comprehensive Assessment documentation will be completed timely. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures.</p> <p>F. The agency will complete a referral form upon receipt of the referral information. All information will be reviewed for completeness and identifying information prior to accepting the referral insuring that the referral is intended for home health not outpatient therapy. The agency referral form will be included in the medical record. All clinical staff (including Clinical Manager) as well as office staff that support the intake role will be educated and trained on these corrective measures.</p> <p>G. Any needed changes</p>	

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	<p>period of 4/17/17 - 6/15/17 evidenced an incomplete document that had been signed by the physician on 4/25/17 and the nurse, Employee B, Registered Nurse, on 4/17/17. This document was not complete. This plan of care failed to give the patient's complete address, a principal diagnosis, and nutritional requirements. The medications on this plan of care included hydrocodone / acetaminophen by mouth tablet 5 - 325 milligrams 2 tablets every 6 hours.</p> <p>C. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a Home Health Certification and Plan of care with a certification period of 4/17/17 - 6/15/17 signed by Employee B, RN, on 4/14/17 and the physician on 5/23/17. This is not a timely physician signature. This was reviewed on 6/9/17.</p> <p>i. During an interview on 6/9/17 at 9:10 AM, the director of nursing indicated the plan of care had been incomplete when it was sent to the physician and needed to be resent to the physician after it had been completed. She did not indicate how this occurred but did indicate this is why there was more than one plan of care for the same certification period.</p>		<p>to a verbal order from its original form, will be documented in the medical record and the physician will be notified of the need to modify the order. The order will be sent to the physician for signature and date. The agency tracking process will apply. All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures to verbal orders.</p> <p>H. Any modifications/errors in documentation will be corrected according to the agency policy "Documentation of Changes to the Medical Record." All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures in documentation.</p> <p>I. The agency aide supervisory note will be accurately completed, dated and signed by the RN or Qualified Therapist and includes all the required documentation of the aide follows patient's plan of care, communicates openly with the patient, family, caregivers, respects the patients' rights, is competent to perform assigned tasks, complies with infections control measures, and appropriately reports any changes in the patient's condition. Documentation is specified to the patient's needs and response to services. The Clinical Manager</p>				

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	<p>3. A review of a document titled "A SN [Skilled Nursing] C2 / ICD10 v 16.3 1. Start of Care - further visits planned on 03- 06- 2017 for patient #3 evidenced the patient had an initial assessment / comprehensive assessment completed in a timely manner. This document was dated 3/6/17 but not signed by Employee L, RN, until 3/16/17.</p> <p>A. During an interview on 6/15/17 at 3:30 PM, the director of nursing indicated that this assessment had not been completed in a timely manner.</p> <p>4. A review of a clinical record #3 document titled "Referral Order" dated 3/1/17 included a physician referral order with an outpatient therapy company's name, address, and fax number, There was no referral made to this agency which is titled "Back Home Again Home Health dba Priority Rehab" and located at 291 N State Road 2 in Valparaiso, IN.</p> <p>A. During an interview on 6/9/17 at 2:30 PM, Employee J, physical therapist and owner and owner and PTA stated, "Communication with our staffing company comes to us."</p> <p>5. A review of clinical record #4 evidenced a document titled "Physician</p>		<p>will in-service RN, PT, OT staff on supervision of the aide and associated required documentation.</p> <p>J. An up-to-date master schedule and patient calendar will be maintained for each patient decreasing the risk of missed visits. A missed visit form will document the event of the missed visit, date, discipline, reason for missed visit, and how patient's needs were met. The physician will be notified of all missed visits and the master schedule and patient schedule will indicate missed visits.</p> <p>K. The agency will maintain the correct and current physician having oversight of the home health care admission in the medical record of patient services and care. The current and accurate physician will be notified in a timely manner of all incidents that affect and/or require modification to the POC. The agency will maintain the current and correct physician with contact information and all required information (i.e. NPI, PECOS, License, and confirmed by patient and physician). The Clinical Manager and all clinical staff to be reeducated and trained on these corrective measures.</p> <p>L. The agency will in-service all professional staff on the following agency policies:</p> <p>Physician Orders Medical Supervision</p>		

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	<p>Order for Start of care" evidenced a verbal order for start of care that failed to identify the home health agency. This order included the name of an outpatient therapy company and its phone number and its fax number. This order signed by the physician and dated 4/6/17 stated, "Agency to have Registered Nurse or Licensed Therapist perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN Instruction on disease management / medication management, PT unsteady gait and muscle weakness, OT safety of environment, ADLS The Registered Nurse / Licensed Therapist will perform a full system assessment inclusive of vital signs and O2 saturation levels, a review / reconciliation of the client's medication regimen, a safety and fall risk assessment, nutrition, skin, depression and pain screenings. The comprehensive assessment will also include a home environment safety assessment and assessment of need for adaptive devices.</p> <p>A. During an interview on 6/19/17 at 11:45 AM, the director of nursing indicated that verbal order form had been changed.</p> <p>6. A review of clinical record #5 with a</p>		<p>Clinical Documentation Clinical Records/Medical Retention Documentation of Changes to the Medical Record</p> <p>The agency staff will sign a statement stating they understand these policies and agree to compliance with these policies. The signed statements will be included in the employees personnel file. Any contract staff will be included in the in-servicing process and will also sign the statement of understanding and compliance. The contract staff signed statement will be included in the contract file. Should errors continue staff will be counseled.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that all changes are noted in the medical record indicating who made the changes, what changes were made, signed and dated by the professional completing the OASIS; that all orders, including POC, are completed accurately; that the Initial Assessment / Comprehensive Assessment is completed within the regular time frames; that the referral form is completed accurately and that the referral is appropriate for the agency; that all changes to the medical record are compliant with the agency policy; that all changes to the medical record</p>				

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	<p>start of care on 5/31/17 evidenced documentation concerns. This review occurred on 6/19/17. This was evidenced as follows:</p> <p>A. A review of the plan of care titled "Home Health Certification and Plan of Care" for the certification period of 5/31/17 - 7/29/17 evidenced the signature of the director of nursing dated 5/31/17. A second document titled "Home Health Certification and Plan of Care" for the certification period evidenced the signature of Employee B, RN, with a date of 5/31/17. The physician signed this plan of care on 6/13/17.</p> <p>B. During an interview on 6/13/17 at 3:30 PM, the director of nursing indicated this was a clerical error. She stated, "I sent it to the physician. I also sent to [employee B] for corrections. This was a clerical error."</p> <p>7. A review of clinical record #6 with a start of care date of 3/1/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p>A. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/30/17 - 6/28/17 evidenced a document</p>		<p>are compliant with agency policy.</p> <p>Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment / Comprehensive Assessment; that the referral process is completed accurately; that Oasis completion is accurate; that changes to the medical record are compliant; that aide supervisory visits are accurate and reflect individualized patient needs; that missed visits are recorded accurately; that the physician on record is accurate and they are notified.</p> <p>3. The administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p> <p>4. Correction date: 08/18/17</p>	

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	<p>that was signed by the Employee B, RN, and signed by the physician on 6/18/17. Employee B, RN, signed the verbal order start of care on 4/29/17.</p> <p>B. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated the plan of care was not signed by the physician in a timely manner.</p> <p>8. A review of clinical record #8 with a start of care date of 6/2/17 evidenced a plan of care with a certification period of 6/8/17 - 8/6/17 and the plan of care not individualized for this patient. This was evidenced as follows:</p> <p>A. A review of a physician order for start of care evidenced a physician order dated 5/31/17 and a start of care 6/1/17 for the skilled nurse to admit and evaluate and treat for home health, PT to evaluate and treat, and OT evaluate and treat."</p> <p>B. A review of a physician verbal order with titled "Orders" with a signature of Employee B dated 6/2/17 stated, "POSOC [physician order start of care] per patient request d/t [due to] still moving in facility."</p> <p>C. A review of the record evidenced a "Home Health Certification and Plan of</p>			

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	<p>care" plan of care document with a date of the RN, Employee B, on 6/8/17 and the physician on 6/15/17. This plan of care evidenced a certification period of 6/8/17 - 8/6/17 and start of care date of 6/2/17. The date of 6/2/17 was inaccurate. The start of care date was 6/8/17. The RN, Employee A, visited the patient on 6/8/17 for the initial assessment / comprehensive assessment.</p> <p>D. During an interview on 6/16/17 at 3:20 PM, the director of nursing indicated the patient delayed the start of care due to moving in to his / her apartment during that time and choosing to delay the start of care. She indicated this was a clerical error.</p> <p>9. A review of the clinical record #10 with a start of care of 4/21/17 evidenced aide supervision notes that were identical from one visit on 6/2/17 to another on 6/8/17 and that the attending physician had been changed to another attending physician and physician orders were still sent to the first attending physician. This was evidenced as follows:</p> <p>Regarding two identical notes:</p> <p>A. A review of an Aide Supervisory Visit dated 6/2/17 and signed by Employee B, Registered Nurse, stated,</p>			

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	<p>"Supervision date 6/2/17, Supervisor name [Employee B, RN], clinician name [Employee O, Home Health Aide (HHA) ], clinician present at time of visit checked "No", Notifies client / caregiver of schedule: Excellent, Reports for duty as assigned [Excellent], Cooperative with client's and others: Excellent, Courteous toward client and others: excellent, Documents appropriately: Excellent, Timely notification to supervisor of client's needs or changes in condition Excellent, no changes made to care plan, patient satisfied with current plan, Comments: No HHA Visits in past 2 weeks. One week daughter in town and was able to assist patient, this week pt refused d / t weakness R / T pneumonia. Pt states feeling improved and requires HHA to come Tuesday, SN [skilled nurse] will confirm with HHA."</p> <p>B. A review of an Aide Supervisory Visit dated 6/8/17 and signed by Employee B, Registered Nurse, stated, "Supervision date 6/8/17, Supervisor name [Employee B, RN], clinician name [Employee O, Home Health Aide ], clinician present at time of visit checked "No", Notifies client / caregiver of schedule: Excellent, Reports for duty as assigned [Excellent], Cooperative with client's and others: Excellent, Courteous toward client and others: excellent,</p>			

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	<p>Documents appropriately: Excellent, Timely notification to supervisor of client's needs or changes in condition Excellent, no changes made to care plan, patient satisfied with current plan, Comments: No HHA Visits in past 2 weeks. One week daughter in town and was able to assist patient, this week pt refused d / t weakness R / T pneumonia. Pt states feeling improved and requires HHA to come Tuesday, SN [skilled nurse] will confirm with HHA."</p> <p>C. During an interview on 6/19/17 at 2:20 PM, the director of nursing indicated the notes were the same except the dates.</p> <p>D. During an interview on 6/19/17 at 2:20 PM, Employee M, physical therapy assistant and owner, stated, "Not a rule that nothing can be changed".</p> <p>Regarding the lack of updating the new attending physician and sent to the physician no longer involved in patient 's care</p> <p>E. A review of the "Home Health Certification and Plan of Care" with a certification date of 4/21/17 - 6/19/17 evidenced a box titled "Physician's Name and Address with the attending physician's name and address. This</p>			

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	<p>physician's name and address were crossed off and error written over this physician's name and address. A second physician's name and NPI (national provider identifier) number were entered below in the box.</p> <p>F. A review of the missed visit form (OT Visit) dated 5/25/17 and signed by Employee D, OT, evidenced this form was sent to the first physician who was no longer the attending physician. This documented stated, "No answer to locked door."</p> <p>G. A review of the missed visit form (COTA Visit) dated 6/2/17 and signed by Employee E, COTA, evidenced this form was sent to the first physician who was no longer the attending physician. This documented stated, "Pt out of town."</p> <p>H. A review of the missed visit form (Physical Therapy Re - Evaluation with Supervisory Visit) dated 6/9/17 and signed by Employee A, Physical Therapist, evidenced this form was sent to the first physician who was no longer the attending physician. This documented stated, "PT. Reports still feeling ill and requesting to reschedule PT visit for next week."</p> <p>I. During an interview on 6/19/17 at</p>				

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	<p>2:30 PM, Employee M and Employee P, receptionist, indicated that the software program was not updating yet and in the next episode this will fix itself.</p> <p>10. The undated agency policy titled "Physician Orders" stated, "All medications, treatments and services provided to clients must be ordered by a physician. The orders must be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. Orders may be received via facsimile. Orders signed by physician may in writing or signed electronically ... verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy ... 1. When the nurse or therapist receives a verbal order from the physician, he / she shall write the order as given and then read the order back to the physician verifying that the person receives the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, the specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature. Verbal orders received during an initial</p>				

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	<p>assessment / evaluation may be documented on the 485 and sent to the physician for signature."</p> <p>11. The undated agency policy titled "Medical Supervision stated, "Physicians will be informed at the time their clients are admitted to the agency, of each parties' responsibilities in managing client's care ... the client's primary physician shall be responsible of approving signed orders and for establishing and reviewing the client's plan of care throughout the time the client is receiving services."</p> <p>12. The undated agency policy titled "Clinical Documentation" stated, "Agency will document each direct contact with the client's. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the client's care. Purpose: To ensure that there is an accurate record of the services provided, client response, and ongoing need for care. To document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement. Special instructions: 1. All skilled services provided by Nursing, Therapy, or Social Services will be documented in the clinical record. 2. A separate note shall</p>			

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	<p>be completed for each visit / shift and signed and dated by the appropriate professional. Actual time and length of the client's visit will be included in each note ... Services not provided and the reason for missed visits will be documented and reported to the physician."</p> <p>13. The undated agency policy titled "Clinical records / Medical Retention" stated, "A clinical record will be maintained for every client receiving home health services. All client's information shall be regarded as confidential and available only to authorized users. Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members. The agency is to use an electronic medical record retention system for client charts. A paper chart may be utilized, and retained according to state guidelines, until the EMR is fully integrated ... Purpose: To maintain an accurate record of the services provided by the agency for each client's. To provide a mechanism by which client's care information is documented, maintained, protected and utilized, and</p>			

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	<p>transferred as appropriate. To safeguard the integrity of information maintained in clinical and billing records. Special instructions: Clinical record. 1. A confidential clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every client receiving home health services ... 4. Documentation shall reflect observations and should be objective and non-judgmental ... 5. Documentation shall establish that effective interchange, reporting, and coordination of care does occur. 6. All documentation must be legible and if written on paper be written in ink [preferably black ] or typewritten ... 9. Since the clinical record is a legal document, no form may be removed or destroyed once it is filed within the chart ... 10. In the event that an employee wishes to correct data, it shall be done as an amendment without change to the original entry. It shall be identified as an additional document appended to the original clinical record."</p> <p>14. The agency document titled "Kinnser Online Help Task and Episode Comments" dated 2017 stated, "Tasks and episode comments also known as yellow and purple sticky notes let you append the information on a task or episode level. This is really useful for</p>						

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	<p>maintaining advisory information related to scheduled task / visit as well as information that applies to the entire episode. The following provides an overview of the available sticky note options available within Kinnser as well as their functions and general use. Yellow stick notes Yellow sticky notes or task comments are located within the Details section of task and are generally used to document extra details or information regarding a particular visit. These task specific comments can be added or edited at any time, regardless of the task's status, and do not appear within the Print View of the visit note. During the review process, a QUA person is able to make comments for correction within the yellow comment box prior to returning in to eh Clinician. Comments made will appear as a yellow sticky note icon within the assigned clinicians' hot box, the QA Manager box, and the patient's episode manager page and can be reviewed by hovering your mouse cursor over the icon. Unlike tasks, however, once a yellow sticky note has been deleted, it cannot be restored."</p> <p>15. The undated agency policy titled "Documentation of Changes to the Medical Record" stated, "Medical records are legal documents that support the delivery of client services. Any changes</p>			

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	<p>or revisions of information documented in the client record must follow accepted legal requirements. Purpose: Documentation provides evidence that the agency provided the client services. The format of the record shows interventions provided according to the plan of care and is consistent with the requirements of the agency standard, Medicare regulations and payer requirements. Accuracy and correct documentation of the OASIS assessments are critical components of reimbursement as well as regulation. Special instructions: 1. All entries into the record must be legible. The use of white out is not allowed. Entries may not be erased or scratched out. 2. When it is necessary to correct an entry in the clinical record: a. draw a single line through the statement. b. Write the date the correction was made and sign with first and last initial. C. Write the correct information. 3. If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to. 4. Changes to OASIS documentation a. The OASIS assessment tool is a legal part of the record. It should not be treated as a worksheet. B. The clinician who completes the assessment form is</p>			

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	responsible of making changes [corrections, revisions, additions] to the document. c. The clinical supervisor or designee may enter changes based on the review of the assessment. These changes must be documented in the record identifying the reason for the changes and the communication of those changes to the authoring clinician. These changes must also be initialed and dated as noted above. 5. Electronic health records ... a. Records sourced from electronic systems containing amendments, corrections, or delayed entries must distinctly identify any amendment, correction or delayed entry and provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the records."			

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G 0330  Bldg. 00	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on home visit observation, record review and interview, the agency failed to complete an accurate initial assessment to determine eligibility for the Medicare home health benefit including homebound status for 5 of 12 records reviewed (see G 131); failed to ensure patients received an initial assessment within 48 hours of referral, 48 hours of return home, or on the physician order</p>	G 0330	<p>1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet the Condition of Participation 484.48 Medical Records. BHA's clinical record documentation process has been redeveloped as follows:</p> <p>A. Only one qualified professional will complete and sign and date the OASIS. If</p>	08/18/2017
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	<p>start of care date for 2 of 12 records reviewed (see G 332); failed to ensure the comprehensive assessment was completed no more than 5 days after the start of care date for 2 of 12 patients reviewed (see G 334); failed to complete an accurate initial assessment to determine eligibility for the Medicare home health benefit including homebound status for 5 of 12 records reviewed (see G 335); failed to ensure comprehensive assessments completed upon the patient's return home from in-patient facilities were complete and accurately reflected the patient's status in 1 of 2 active records reviewed of patients who had a resumption of care and were completed within 48 hours of the patient's return home from an in - patient facility (see G 340); and failed to ensure a comprehensive discharge assessment was completed for 1 of 1 discharged records reviewed (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide a complete comprehensive assessment that accurately reflects the patients' status for the Condition of participation CFR 484.55 Comprehensive Assessment of Patients.</p>		<p>modifications are required to the OASIS, the reviewer will consult with the staff person who completes the OASIS who will then decide about any changes to be made. All changes to the OASIS will be documented as to what changes were made, who made the changes, and signed and dated by the professional completing the OASIS. This will be incorporated in the Medical Record. The OASIS Guidance Manual is a resource for the completion of the OASIS and a copy is in the office.</p> <p>B. The POC will be developed based on the patient's needs and in collaboration with the physician. The POC will include all the required data accurately documented including a complete and accurate medication list, frequency and duration of involved services, and signature and date of the Registered Nurse or Therapist responsible for the development of the POC. The POC will indicate the patient's individualized care plan specific to their assessed needs.</p> <p>C. The POC will be signed and dated by the physician in a timely manner, within 30 days, of the SOC, and documentation will evidence the return of the signed POC in a timely manner and tracking of the order and all attempts to have the POC returned signed in a timely manner.</p>		

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			<p>D. The Verbal SOC order will be documented and reflected on the POC with the RN or Therapists signature and date.</p> <p>E. This agency will complete an Initial Assessment/ Comprehensive Assessment in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or on the physician ordered SOC date. As stated in correction D above the Verbal SOC order will be documented and reflected on the POC &amp; in the patient record with the RN or Therapists signature and date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed needs. In addition, the Initial Assessment/ Comprehensive Assessment documentation will be completed timely. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures. The Comprehensive Assessment will be completed within 5 days as required.</p> <p>F. The agency will complete a referral form upon receipt of the referral information. All information will be reviewed for completeness and identifying information prior to accepting the referral insuring that the referral is intended for home health not outpatient therapy. The agency referral form will be included in</p>	

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			<p>the medical record. All clinical staff (including Clinical Manager) as well as office staff that support the intake role will be educated and trained on these corrective measures.</p> <p>G. Any needed changes to a verbal order from its original form, will be documented in the medical record and the physician will be notified of the need to modify the order. The order will be sent to the physician for signature and date. The agency tracking process will apply. All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures to verbal orders.</p> <p>H. Any modifications/errors in documentation will be corrected according to the agency policy "Documentation of Changes to the Medical Record." All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures in documentation.</p> <p>I. The agency aide supervisory note will be accurately completed, dated and signed by the RN or Qualified Therapist and includes all the required documentation of the aide follows patient's plan of care, communicates openly with the patient, family, caregivers, respects the patients' rights, is competent to perform assigned</p>	

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			<p>tasks, complies with infections control measures, and appropriately reports any changes in the patient's condition. Documentation is specified to the patient's needs and response to services. The Clinical Manager will in-service RN, PT, OT staff on supervision of the aide and associated required documentation.</p> <p>J. An up-to-date master schedule and patient calendar will be maintained for each patient decreasing the risk of missed visits. A missed visit form will document the event of the missed visit, date, discipline, reason for missed visit, and how patient's needs were met. The physician will be notified of all missed visits and the master schedule and patient schedule will indicate missed visits.</p> <p>K. The agency will maintain the correct and current physician having oversight of the home health care admission in the medical record of patient services and care. The current and accurate physician will be notified in a timely manner of all incidents that affect and/or require modification to the POC. The agency will maintain the current and correct physician with contact information and all required information (i.e. NPI, PECOS, License, and confirmed by patient and physician). The Clinical Manager and all clinical staff to be reeducated and trained</p>	

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			<p>on these corrective measures.</p> <p>L. The agency will in-service all professional staff on the following agency policies:</p> <p>Physician Orders Medical Supervision Clinical Documentation Clinical Records/Medical Retention Documentation of Changes to the Medical Record</p> <p>The agency staff will sign a statement stating they understand these policies and agree to compliance with these policies. The signed statements will be included in the employees personnel file. Any contract staff will be included in the in-servicing process and will also sign the statement of understanding and compliance. The contract staff signed statement will be included in the contract file. Should errors continue staff will be counseled.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that all changes are noted in the medical recorded indicating who made the changes, what changes were made, signed and dated by the professional completing the OASIS; that all orders, including POC, are completed accurately; that the Initial Assessment / Comprehensive Assessment is completed within the regular time</p>	

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G 0331  Bldg. 00	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit,		frames; that the referral form is completed accurately and that the referral is appropriate for the agency; that all changes to the medical record are compliant with the agency policy; that all changes to the medical record are compliant with agency policy.  Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment / Comprehensive Assessment; that the referral process is completed accurately; that Oasis completion is accurate; that changes to the medical record are compliant; that aide supervisory visits are accurate and reflect individualized patient needs; that missed visits are recorded accurately; that the physician on record is accurate and they are notified.  3. The Administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.  4. Correction Date: 08/18/17	

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	<p>including homebound status.</p> <p>Based on home visit observation, record review and interview, the agency failed to complete an accurate initial assessment to determine eligibility for the Medicare home health benefit including homebound status for 5 of 12 records reviewed (#1, #4, #5, #9, #11).</p> <p>The findings include:</p> <p>1. A review of Clinical record #1's record with a start of care (SOC) 5/22/17 evidenced an incomplete and inaccurate initial assessment. The patient was able to complete ADLs (activities of daily living) independently and this assessment did not show that this could occur accurately. Plus the assessment evidenced the patient had caregivers to help with these tasks but did not complete the section of supportive assistance who completed these tasks under M1100. The patient was not homebound. This patient had Medicare as a payor source. This was evidenced by the following:</p> <p>A. A review of Clinical record #1 failed to evidence a complete and accurate OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment. There were two of these documents dated 5/22/17. One was signed by the director of nursing and the</p>	G 0331	<p><b>G331 Initial Assessment Visit</b></p> <p>1)The agency will immediately complete an accurate initial assessment of all patients to determine admission for a home health episode which may include a comprehensive assessment. Medicare patients not accepted for admission following initial assessment will receive the CMS NOMNC.</p> <p>A. All direct care staff (RN, PT, OT &amp; ST) will receive reeducation and training on completing an accurate initial patient assessment. Admitting professional shall document immediate care &amp; support needs and homebound status for Medicare. This includes skilled &amp; Paraprofessional needs. This includes coordination of care with team members to identify discrepancies in clinical data and patient criteria for admission.</p> <p>B. The agency will contract an external QA (associated with the new</p>	08/04/2017			

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	<p>other signed by Employee B, Registered Nurse and both of these were in the clinical record. This review occurred on 6/19/17. Both documents revealed the patient lives in a congregate situation. The section titled "M1100 ... Type of Assistance Receives - other than from home health agency staff was left blank. This included ADL (bathing, dressing, toileting, bowel / bladder, eating / feeding), IADLs (instrumental activities of daily living scale: meds, meals, housekeeping, laundry, telephone, shopping, finances), psychosocial support, assistance with medical appointments, delivery of medications, and management of finances). Under this was the name of Supportive assistance: Names of organizations providing assistance. This was left blank. Under the home bound section, a box was checked "Yes." Under this was checked a box titled "Residual weakness" and "Requires Max assistance / taxing effort to leave home and "Unable to safely leave home unassisted." The box titled "M1810 Current Ability to dress upper body safely [with or without dressing aids] including undergarments, pullovers, front - opening shirts and blouses, managing zippers, buttons, and snaps ... able to dress upper body without assistance if clothing laid out or handed to the patient ... M 1820 Current ability to</p>		<p>EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. Final review and submission to be approved by the Clinical Manger or alternate. All modifications to the original submission to be documented on a modification revision form, signed by all parties, and incorporated into the patients' chart. The Clinical Manager will review the external QA report before locking Oasis. 2) Clinical Manager to audit B and review all initial assessments for required content and patient meeting the required elements for admission to home health prior to locking and approving the Oasis for submission to CMS. 100% of new admissions after 08/04/17 to be audited for 3 months then 10% completed quarterly. 3) The Administrator and Clinical Manager (DON) are responsible.</p>	

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	<p>dress lower body safely [with or without dressing aids] including undergarments, slacks, socks, or nylons, shoes ... 2. Someone must help the patient put on undergarments, slacks, socks, or nylons, and shoes ... M 1830 Bathing Current ability to wash entire body safely ... able to bathe in shower or tub independently, including get in and out of tub / shower ... M 1840 Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode ... 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer ... Transferring ... 2. Able to bear weight and pivot during the transfer process but unable to transfer self ... GG0170C Mobility Code the patient's usual performance at the SOC / ROC using the 6 point scale ... Coding: Safety and Quality of Performance ... 03 ... Partial or moderate assistance - helper does less than half the effort. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort ... M 1860 Ambulation / location ... able to walk only with the supervision or assistance of another person at all times ... M 2020 Management of Oral Medication ... Unable to take medication unless administered by another person ... M 2102 Types and sources of assistance</p>		4) Date of Compliance is 08/04/17	

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	<p>... Type of assistance ADL assistance [for example, transfer, ambulation, bathing, dressing, toileting, eating / feeding) ... non- agency caregivers currently providing assistance." Also marked in the 2102 box was that the IADLs assistance was completed with assistance, medication administered by a nonagency caregiver, supervision and safety. All of this assistance was provided at least daily. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy (PT) evaluation visit completed on 5/22/17 at 3:38 PM evidenced the patient lived alone in a apartment in an independent living facility and has caregivers who assist with housekeeping and meal preparation. This was signed by Employee A, PT.</p> <p>C. A OT (occupational therapy) evaluation visit signed by Employee D, OT, dated 5/22/17 with a time of 2:50 PM stated, "Pt. ambulated with rolling walker and completed all ADL's and transfers with Mod [Modified] I / independently ... Pt. lives in ILF [independent living facility], pt's family lives nearby and able to assist with transportation, facility responsible for</p>			

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	<p>housekeeping and meal preparation ... Pt. lives in ILF, has shower chair with grab bars in WIS [walk in shower] and grab bars near toilet.</p> <p>D. A certified occupational therapy assistant visit dated 5/25/17 at 1 PM evidenced the patient is able to sit to stand with stand by assist. This was signed by Employee E, COTA.</p> <p>E. A physical therapy assistant (PTA) visit signed by Employee C and dated 5/25/17 at 14:10 PM evidenced the patient was able to transfer from sit to stand and from stand to sit with stand by assist. There was no physical help given. The patient completed exercises on the Nu - Step machine.</p> <p>F. A physical therapy assistant visit signed by Employee C, PTA dated 6/1/17 at 13:36 PM evidenced the patient was able to transfer with sit / stand and stand / sit with stand by assist and was able to ambulate X 300 feet with rollator walker. The patient warmed up on a Nu - step machine at this visit.</p> <p>G. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care document evidenced a blank face to face encounter</p>				

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	<p>on 6/8/17 with no physician notes or encounter or signature.</p> <p>H. During an interview on 6/19/17 at 10:35 AM, the director of nursing indicated that this patient was homebound and caregivers provided care to the patient. She did indicate that the assessment was not completely filled out.</p> <p>I. During an interview with patient #1 on 6/19/17 at 12:10 PM, patient #1 indicated the ability to complete all activities of daily living independently including eating, dressing, toileting, transferring, transferring, and walking. She indicated that she was not homebound and was able to go out with friends and family to shop. She was able to walk to her physical therapy / occupational therapy in the rehab. room in the independent living without difficulty. She indicated she did not have caregivers help her with activities of daily living such as toileting, dressing, grooming, or bathing.</p> <p>2. A review of Clinical record #4's record included a start of care 4/21/17 and evidenced an incomplete and inaccurate initial assessment. The SN assessment in finding #A evidenced the patient was homebound and had a difficult time leaving the home. The PT</p>						

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	<p>and OT evaluations showed the patient was able to leave the apartment with a rolling walker. The patient had Medicare for the payor source. This was evidenced by the following:</p> <p>A. A review of a start of care "SN - Nursing C2 / ICD 10 v. 16.3" dated 4/7/17 and signed by Employee B, RN, on 4/21/17 evidenced an initial assessment that showed the patient was homebound and had a difficult and taxing effort to leave home and requires assist of 1 - 2 people. This document evidenced the patient was alert and oriented. This is not accurate as shown in finding #B - #D below:</p> <p>B. A review of a Physical Therapy evaluation signed by Employee A, physical therapist, dated 4/11/17 with a time in of 2:18 PM and time out of 3:04 PM stated that this patient uses rollater walker outside of apartment and lives in a independent living facility. The Tinetti Assessment completed on 4/11/17 was included in this evaluation visit and evidenced the patient was able to arise without using arms.</p> <p>C. A review of an Occupational Therapy Evaluation signed by Employee D, OT, dated 4/11/17 with a time in of 1:30 PM and time out of 2:11 PM</p>			

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	<p>evidenced the patient was able to complete bed mobility, toilet transfer, dynamic sitting balance, and static standing balance with stand by assist. A tub / shower assist and dynamic standing balance was completed by the patient with minimal assist. The patient is able to self feed and toilet with modified independent function. The patient is able to complete oral hygiene, groom, upper body bathing.</p> <p>D. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>3. A review of Clinical record #5's record with a start of care 5/31/17 evidenced an incomplete and inaccurate initial assessment. The patient lived in an</p>			

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	<p>independent living facility and had no knowledge of receiving home health agency care. The patient's payer source was Medicare. This was evidenced by the following:</p> <p>A. A OASIS - C2 Start of care assessment document dated 5/31/17 and signed by Employee C, Registered Nurse, was not complete or accurate. The section titled "Type of Assistance Patient Receives" had not been completed including who provided ADL assist / bathing, dressing, toileting, bowel / bladder, eating / feeding.</p> <p>M 2012 The Types and Sources of Assistance evidenced that the patient had nonagency caregivers currently providing assistance with ADL's and that this assistance was provided 3 times a week or more. The M 1860 ambulation / locomotion section indicated the patient could only walk with the supervision or assistance of another person at all times. The GO170C mobility section evidenced the patient needed partial / moderate assistance: the helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort. This assessment also stated that the patient is able to bear weight and pivot with transfer process but unable to transfer self. M 1700 Functioning is alert and oriented and able to focus and shift</p>			

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	<p>attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy evaluation signed by Employee A, PT, and dated 6/1/17 evidenced the patient lived in an independent living facility. Patient is oriented to person, place, time. Patient is able to sit to stand, stand to sit, and toilet with stand by assist.</p> <p>C. An OT evaluation dated 6/1/17 and signed by Employee D, OT, evidenced this patient lived in Independent Living facility. The patient is able to ambulate with assistive device and completed all ADL's and transfers with Modified Independent / Independently.</p> <p>D. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency. The patient indicated enjoying activities at the facility where he / she lived including dances and was able to participate in these dances.</p>			

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	<p>E. During an interview on 6/19/17 at 12 noon, the director of nursing and Employee I, RN, stated, "[He / she] has good days and bad days."</p> <p>F. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care" evidenced a blank face to face encounter on 6/15/17.</p> <p>4. A review of clinical record #9 with a start of care of 4/6/17 evidenced an incomplete and inaccurate initial assessment. The payer source is Medicare. This was evidenced by the following:</p> <p>A. A review of an OASIS - C2 Start of Care assessment completed on 4/6/17 with a signature of Employee K, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. Types and sources of assistance ADL assistance was checked that non - agency caregivers were currently providing assistance. M1810 and M 1820 evidenced the patient was able to dress self if clothes were laid or handed to patient. The mobility section numbered GG010C stated, "Safety and quality of</p>			

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	<p>performance - the patient needed supervision or touching assistance - helper sets up or cleans up and patient completes activity.</p> <p>B. A review of a occupational therapy evaluation dated 4/7/17 and signature of Employee D, OT, evidenced the patient was independent with bathing and dressing.</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated he / she was able to attend therapy sessions in the therapy room away from his / her apartment.</p> <p>D. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time/person/place). Patient's physician indicated not being aware of patient's home status.</p> <p>5. A review of clinical record #11 with a start of care 5/24/17 evidenced an incomplete and inaccurate initial assessment. This patient lived alone and was able to complete ADLs independently. The payer source is Medicare. The initial assessment did not show that the patient had this level of independence. This was evidenced by the following:</p>			

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	<p>A. A review of an OASIS-C2 Start of Care assessment completed on 5/24/17 with a signature of Employee B, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. The M2102 Types and Sources of Assistance evidenced boxes checked that included the following: ADL assistance nonagency caregiver provide assistance, IADL assistance box checked that non-agency currently provide assistance, supervision and safety box was checked that non-agency caregiver provide assistance. These caregivers provided assistance one two times per week. The patient's mobility was shown as a 04 which meant that supervision or touching assistance was provided and a helper provides verbal cues or touching / steadying assistance as patient completes activity. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A review of an OT evaluation completed on 5/30/17 completed by Employee D, OT, evidenced patient could complete grooming with minimal</p>			

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	<p>assist, dress the lower body with minimal assist and toilet with supervision.</p> <p>C. During a home visit observation on 6/13/17 at 11:15 AM, patient #11 was observed to answer door independently and was able to transfer per self and ambulate per self.</p> <p>D. During a home visit observation interview on 6/13/17 at 12 noon, patient #11 indicated living alone in an independent living facility and being able to perform tasks like dressing independently.</p> <p>6. The undated agency policy titled "Clinical records / Medical Record Retention" stated, "Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members ... documentation shall reflect observations and should be objective and non- judgmental."</p> <p>7. The undated agency policy titled "Client Admission Process" stated, "Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate</p>			

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	<p>care and support needs of the client; and for Medicare clients, to determine the eligibility for the Medicare Home Health benefit."</p> <p>8. During the entrance conference on 6/8/17 at 11 AM, the director of nursing indicated the initial and comprehensive assessments were combined in a start of care assessment and not usually completed separately but could be.</p>			

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G 0332  Bldg. 00	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on record review and interview, the agency failed to ensure patients received an initial assessment within 48 hours of referral, 48 hours of return home, or on the physician order start of care date for 2 of 12 records reviewed (#1, #3).</p> <p>The findings include:</p> <p>1. A review of record #1 evidenced a referral order dated 5/8/17 and a verbal order / referral dated 5/19/17 and the initial assessment was not completed until 5/22/17. This was evidenced by the following:</p>	G 0332	<p><b>G332 Initial Assessment Visit</b></p> <p>1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet 484.55(a)(1) Initial Assessment Visit. BHA's clinical record documentation process has been redeveloped as follows:</p> <p>A. This agency will complete an Initial Assessment which may also include a Comprehensive Assessment in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or</p>	08/18/2017

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	<p>A. A review of the record on 6/8/17 evidenced a physician order dated 5/8/17 that stated, "Physical Therapy Consult and Treat DX [Diagnosis] Generalized deconditioning Right shoulder pain." This was signed by the physician. A fax date of 5/11/17 and the name of the independent living were also on the document. This order did not mention home health services.</p> <p>B. A review of a skilled nurse narrative charting coordination of care charting dated 5/19/17 and signed by the director of nursing. This note stated, "T.C. [telephone call] to [physician's] office to request orders for SN [skilled nurse] to admit, PT [physical therapy], OT [occupational therapy] to evaluate and treat. [agency] received referral however we need signed Dr. Order to proceed. Spoke c [with] nurse who stated write order to Dr. Fax over Dr. will sign and fax back ASAP [as soon as possible].</p> <p>C. A review of a document titled "Physician Order for Start of Care" with patient #1's name and date of birth evidenced a verbal order was received from [name of referral person] at 5:15 PM on 5/19/17. There was a request for PT and OT. There was not an order for</p>		<p>on the physician ordered SOC date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed needs. In addition, the Initial Assessment/ Comprehensive Assessment documentation will be completed timely. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that the Initial Assessment / Comprehensive Assessment is completed within the regular time frames. Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment / Comprehensive Assessment. Should errors continue staff will be counseled.</p> <p>3. The Administrator and Clinical Manager are responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p> <p>4. Correction Date: 08/18/17</p>	

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	<p>Skilled Nurse. This was signed by Employee A, Physical Therapist, on 5/19/17. The physician had not signed this order.</p> <p>D. A review of a document titled "OASIS C2 Start of Care dated 5/22/17 and signed by the director of nursing evidenced the initial assessment was not completed within the 48 hours required after the referral.</p> <p>E. A review of a document titled "OASIS C2 Start of Care dated 5/22/17 and signed by Employee B, Registered Nurse, evidenced the initial assessment was not completed within the 48 hours required after the referral. This document was the identical document except for the nurses' signatures as in finding #C above.</p> <p>2. A review of a document titled "A SN [Skilled Nursing] C2 / ICD10 v 16.3 1. Start of Care - further visits planned on 03- 06- 2017 for patient #3 evidenced the patient had an initial assessment / comprehensive assessment completed. This document was dated 3/6/17 but not signed by Employee L, RN, until 3/16/17.</p> <p>A. During an interview on 6/15/17 at 3:30 PM, the director of nursing indicated that this assessment had not been completed in a timely manner.</p>			

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G 0334  Bldg. 00	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on record review and interview, the agency failed to ensure the comprehensive assessment was completed no more than 5 days after the start of care date for 2 of 12 patients reviewed (#3, #4).</p> <p>The findings include:</p> <p>1. A review of a document titled "A SN [Skilled Nursing] C2 / ICD10 v 16.3 1. Start of Care - further visits planned on 03- 06- 2017 for patient #3 evidenced the patient had an initial assessment / comprehensive assessment completed. This document was dated 3/6/17 but not signed by Employee F, RN, until 3/16/17.</p> <p>A. During an interview on 6/15/17 at 3:30 PM, the director of nursing</p>	G 0334	<p>1)All professional staff will be educated that the comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>2)100%of all new admissions after 08/04/17 will be audited for compliance x3months and then 10% quarterly. Should errors and/or delinquent submissions continue staff will be counseled.</p>	08/18/2017

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G 0335 Bldg. 00	<p>indicated that this assessment had not been completed in a timely manner.</p> <p>2. A review of a document titled "A SN C2 / ICD10 v 16.3 1. Start of Care - further visits planned on 04- 07- 2017 for patient #4 evidenced the patient had an initial assessment / comprehensive assessment completed. This document was dated 4/7/17 but not signed by Employee B, RN, until 4/21/17.</p> <p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on home visit observation, record review and interview, the agency failed to complete an accurate comprehensive assessment to determine eligibility for the Medicare home health benefit including homebound status for 5 of 12 records reviewed (#1, #4, #5,#9, #11).</p> <p>The findings include:</p>			G 0335	<p>3) The Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance is 08/18/17.</p> <p><b>G335 Completion of the Comprehensive Assessment</b> 1)The agency will immediately complete an accurate &amp; comprehensive assessment of all patients admitted for a home health episode, recertifications or</p>		08/04/2017

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	<p>1. A review of Clinical record #1's record with a start of care (SOC) 5/22/17 evidenced an incomplete and inaccurate comprehensive assessment. The patient was able to complete ADLs (activities of daily living) independently and this assessment did not show that this could occur accurately. Plus the assessment evidenced the patient had caregivers to help with these tasks but did not complete the section of supportive assistance who completed these tasks under M1100. The patient was not homebound and had Medicare as a payer source. This was evidenced by the following:</p> <p>A. A review of Clinical record #1 failed to evidence a complete and accurate OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment. There were two of these documents dated 5/22/17. One was signed by the director of nursing and the other signed by Employee B, Registered Nurse and both of these were in the clinical record. This review occurred on 6/19/17. Both documents revealed the patient lives in a congregate situation. The section titled "M1100 ... Type of Assistance Receives - other than from home health agency staff was left blank. This included ADL (bathing, dressing,</p>		<p>resumption of care.</p> <p>A. All direct care staff (RN, PT, OT &amp; ST) will receive reeducation and training on completing an accurate initial patient assessment &amp; reassessments. Admitting professional shall document immediate care &amp; support needs and comprehensive homebound status for Medicare. This includes skilled &amp; Paraprofessional needs. This includes coordination of care with team members to identify discrepancies in clinical data and patient criteria for admission.</p> <p>B. The agency will contract an external QA (associated with the new EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. Any discrepancies will be discussed in team conference. Final review and submission to be approved by the Clinical Manger or alternate. All</p>	

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	<p>toileting, bowel / bladder, eating / feeding), IADLs (instrumental activities of daily living scale: meds, meals, housekeeping, laundry, telephone, shopping, finances), psychosocial support, assistance with medical appointments, delivery of medications, and management of finances). Under this was the name of Supportive assistance: Names of organizations providing assistance. This was left blank. Under the home bound section, a box was checked "Yes." Under this was checked a box titled "Residual weakness" and "Requires Max assistance / taxing effort to leave home and "Unable to safely leave home unassisted." The box titled "M1810 Current Ability to dress upper body safely [with or without dressing aids] including undergarments, pullovers, front - opening shirts and blouses, managing zippers, buttons, and snaps ... able to dress upper body without assistance if clothing laid out or handed to the patient ... M 1820 Current ability to dress lower body safely [with or without dressing aids] including undergarments, slacks, socks, or nylons, shoes ... 2. Someone must help the patient put on undergarments, slacks, socks, or nylons, and shoes ... M 1830 Bathing Current ability to wash entire body safely ... able to bathe in shower or tub independently, including get in and out of tub / shower</p>		<p>modifications to the original submission to be documented on a modification revision form, signed by all parties, and incorporated into the patients' chart. 100% of new admissions &amp; recertifications after 08/04/17 to be audited for 3 months then 10% completed quarterly. 2) Clinical Manager to audit B and review all comprehensive assessments for required content and patient meeting the required elements for admission to or continuation of home health prior to locking and approving the Oasis for submission to CMS. 100% of new admissions after 08/04/17 to be audited for 3 months and then 10% completed quarterly. 3) The Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance is 08/04/17</p>	

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	<p>... M 1840 Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode ... 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer ... Transferring ... 2. Able to bear weight and pivot during the transfer process but unable to transfer self ... GG0170C Mobility Code the patient's usual performance at the SOC / ROC using the 6 point scale ... Coding: Safety and Quality of Performance ... 03 ... Partial or moderate assistance - helper does less than half the effort. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort ... M 1860 Ambulation / location ... able to walk only with the supervision or assistance of another person at all times ... M 2020 Management of Oral Medication ... Unable to take medication unless administered by another person ... M 2102 Types and sources of assistance ... Type of assistance ADL assistance [for example, transfer, ambulation, bathing, dressing, toileting, eating / feeding) ... non- agency caregivers currently providing assistance." Also marked in the 2102 box was that the IADLs assistance was completed with assistance, medication administered by a nonagency caregiver, supervision and safety. All of</p>			

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	<p>this assistance was provided at least daily. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy (PT) evaluation visit completed on 5/22/17 at 3:38 PM evidenced the patient lived alone in a apartment in an independent living facility and has caregivers who assist with housekeeping and meal preparation. This was signed by Employee A, PT.</p> <p>C. A OT (occupational therapy) evaluation visit signed by Employee D, OT, dated 5/22/17 with a time of 2:50 PM stated, "Pt. ambulated with rolling walker and completed all ADL's and transfers with Mod [Modified] I / independently ... Pt. lives in ILF [independent living facility], pt's family lives nearby and able to assist with transportation, facility responsible for housekeeping and meal preparation ... Pt. lives in ILF, has shower chair with grab bars in WIS [walk in shower] and grab bars near toilet.</p> <p>D. A certified occupational therapy assistant visit dated 5/25/17 at 1 PM evidenced the patient is able to sit to stand with stand by assist. This was</p>			

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	<p>signed by Employee E, COTA.</p> <p>E. A physical therapy assistant (PTA) visit signed by Employee C and dated 5/25/17 at 14:10 PM evidenced the patient was able to transfer from sit to stand and from stand to sit with stand by assist. There was no physical help given. The patient completed exercises on the Nu - Step machine.</p> <p>F. A physical therapy assistant visit signed by Employee C, PTA dated 6/1/17 at 13:36 PM evidenced the patient was able to transfer with sit / stand and stand / sit with stand by assist and was able to ambulate X 300 feet with rollator walker. The patient warmed up on a Nu - step machine at this visit.</p> <p>G. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care document evidenced a blank face to face encounter on 6/8/17 with no physician notes or encounter or signature.</p> <p>H. During an interview on 6/19/17 at 10:35 AM, the director of nursing indicated that this patient was homebound and caregivers provided care to the patient. She did indicate that the assessment was not completely filled out.</p>			

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	<p>I. During an interview with patient #1 on 6/19/17 at 12:10 PM, patient #1 indicated the ability to complete all activities of daily living independently including eating, dressing, toileting, transferring, transferring, and walking. She indicated that she was not homebound and was able to go out with friends and family to shop. She was able to walk to her physical therapy / occupational therapy in the rehab. room in the independent living without difficulty. She indicated she did not have caregivers help her with activities of daily living such as toileting, dressing, grooming, or bathing.</p> <p>2. A review of Clinical record #4's record included a start of care 4/21/17 and evidenced an incomplete and inaccurate comprehensive assessment. The SN assessment in finding #A evidenced the patient was homebound and had a difficult time leaving the home. The PT and OT evaluations showed the patient was able to leave the apartment with a rolling walker. Payer source is Medicare. This was evidenced by the following:</p> <p>A. A review of a start of care "SN - Nursing C2 / ICD 10 v. 16.3" dated 4/7/17 and signed by Employee B, RN, on 4/21/17 evidenced an initial</p>			

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	<p>assessment that showed the patient was homebound and had a difficult and taxing effort to leave home and requires assist of 1 - 2 people. This patient was alert and oriented. This is not accurate as shown in finding #B - #D below:</p> <p>B. A review of a Physical Therapy evaluation signed by Employee A, physical therapist, dated 4/11/17 with a time in of 2:18 PM and time out of 3:04 PM stated that this patient uses rollater walker outside of apartment and lives in a independent living facility. The Tinetti Assessment completed on 4/11/17 was included in this evaluation visit and evidenced the patient was able to arise without using arms.</p> <p>C. A review of an Occupational Therapy Evaluation signed by Employee D, OT, dated 4/11/17 with a time in of 1:30 PM and time out of 2:11 PM evidenced the patient was able to complete bed mobility, toilet transfer, dynamic sitting balance, and static standing balance with stand by assist. A tub / shower assist and dynamic standing balance was completed by the patient with minimal assist. The patient is able to self feed and toilet with modified independent function. The patient is able to complete oral hygiene, groom, upper body bathing.</p>			

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	<p>D. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>3. A review of Clinical record #5's record with a start of care 5/31/17 evidenced an incomplete and inaccurate comprehensive assessment. The patient lived in an independent living facility and had no knowledge of receiving home health agency care. Payer source is Medicare. This was evidenced by the following:</p> <p>A. A OASIS - C2 Start of care assessment document dated 5/31/17 and signed by Employee C, Registered Nurse, was not complete or accurate. The section titled "Type of Assistance Patient</p>			

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	<p>Receives" had not been completed including who provided ADL assist / bathing, dressing, toileting, bowel / bladder, eating / feeding.</p> <p>M 2012 The Types and Sources of Assistance evidenced that the patient had nonagency caregivers currently providing assistance with ADL's and that this assistance was provided 3 times a week or more. The M 1860 ambulation / locomotion section indicated the patient could only walk with the supervision or assistance of another person at all times. The GO170C mobility section evidenced the patient needed partial / moderate assistance: the helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort. This assessment also stated that the patient is able to bear weight and pivot with transfer process but unable to transfer self. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy evaluation signed by Employee A, PT, and dated 6/1/17 evidenced the patient lived in an independent living facility. Patient is oriented to person, place, time. Patient is able to sit to stand, stand to sit, and toilet with stand by assist.</p>			

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	<p>C. An OT evaluation dated 6/1/17 and signed by Employee D, OT, evidenced this patient lived in Independent Living facility. The patient is able to ambulate with assistive device and completed all ADL's and transfers with Modified Independent / Independently.</p> <p>D. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency. The patient indicated enjoying activities at the facility where he / she lived including dances and was able to participate in these dances.</p> <p>E. During an interview on 6/19/17 at 12 noon, the director of nursing and Employee I, RN, stated, "[He / she] has good days and bad days."</p> <p>4. A review of clinical record #9 with a start of care of 4/6/17 evidenced an incomplete and inaccurate comprehensive assessment. Medicare is payer source. This was evidenced by the following:</p>						

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	<p>A. A review of an OASIS - C2 Start of Care assessment completed on 4/6/17 with a signature of Employee K, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. Types and sources of assistance ADL assistance was checked that non - agency caregivers were currently providing assistance. M1810 and M 1820 evidenced the patient was able to dress self if clothes were laid or handed to patient. The mobility section numbered GG010C stated, "Safety and quality of performance - the patient needed supervision or touching assistance - helper sets up or cleans up and patient completes activity.</p> <p>B. A review of a occupational therapy evaluation dated 4/7/17 and signature of Employee D, OT, evidenced the patient was independent with bathing and dressing.</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated he / she was able to attend therapy sessions in the therapy room away from his / her apartment.</p>			

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	<p>D. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented X 3 and not aware of home bound status.</p> <p>5. A review of clinical record #11 with a start of care 5/24/17 evidenced an incomplete and inaccurate comprehensive assessment. This patient lived alone and was able to complete ADLs independently. The initial assessment did not show that the patient had this level of independence. Medicare is payer source. This was evidenced by the following:</p> <p>A. A review of an OASIS-C2 Start of Care assessment completed on 5/24/17 with a signature of Employee B, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. The M2102 Types and Sources of Assistance evidenced boxes checked that included the following: ADL assistance nonagency caregiver provide assistance, IADL assistance box checked that non-agency currently provide assistance, supervision and safety box was checked that non-agency caregiver provide</p>			

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	<p>assistance. These caregivers provided assistance one two times per week. The patient's mobility was shown as a 04 which meant that supervision or touching assistance was provided and a helper provides verbal cues or touching / steadying assistance as patient completes activity. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A review of an OT evaluation completed on 5/30/17 completed by Employee D, OT, evidenced patient could complete grooming with minimal assist, dress the lower body with minimal assist and toilet with supervision.</p> <p>C. During a home visit observation on 6/13/17 at 11:15 AM, patient #11 was observed to answer door independently and was able to transfer per self and ambulate per self.</p> <p>D. During a home visit observation interview on 6/13/17 at 12 noon, patient #11 indicated living alone in an independent living facility and being able to perform tasks like dressing independently.</p> <p>6. The undated agency policy titled "Clinical records / Medical Record</p>			

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	<p>Retention" stated, "Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members ... documentation shall reflect observations and should be objective and non- judgmental."</p> <p>7. The undated agency policy titled "Client Admission Process" stated, "Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine the eligibility for the Medicare Home Health benefit."</p> <p>8. During the entrance conference on 6/8/17 at 11 AM, the director of nursing indicated the initial and comprehensive assessments were combined in a start of care assessment and not usually completed separately but could be.</p>			

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G 0340  Bldg. 00	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.			

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	<p>Based on record review and interview, the agency failed to ensure comprehensive assessments completed upon the patient's return home from in-patient facilities were complete and accurately reflected the patient's status in 1 of 2 active records reviewed of patients who had a resumption of care and were completed within 48 hours of the patient's return home from an in - patient facility (#3).</p> <p>The findings include:</p> <p>1. Clinical record #3 included a resumption of care assessment dated 6/5/17 after a patient's return from an inpatient hospital stay. The patient had been in the hospital from 5/31/17 - 6/2/17. Employee B, Registered Nurse, completed this clinical document titled "OASIS C2 Resumption of Care on 6/5/17.</p> <p>A. A hospital document titled with the patient's name and hospital name stated, "Date of admission 5/31/17 and date of discharge 6/2/17.</p> <p>B. A review of the record evidenced a ROC (resumption of care) order dated 6/5/17. Priority Rehab Home Health is to resume home health services following the patient admission at [name of</p>	G 0340	<p><b>G340 Update of the Comprehensive Assessment</b></p> <p>1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet 484.55(d)(2) Update of the Comprehensive Assessment. BHA's clinical record documentation process has been redeveloped as follows:</p> <p>A. This agency will complete an Initial Assessment/ Comprehensive Assessment in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or on the physician ordered SOC date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed needs. The Comprehensive Assessment documentation will be completed within 5 days. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures. RN Case Managers are to follow all patients.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that the Initial Assessment / Comprehensive Assessment is completed within the regular time</p>	08/18/2017			

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G 0341 Bldg. 00	<p>hospital] from 6/1/17 - 6/4/17. 6/5/17 is the start date for the ROC. Tramadol 50 mg twice a day was added as a new medication. The diagnosis was T 12 compression fracture. The was signed by Employee B, RN.</p> <p>2. During an interview on 6/19/17 at 2:50 PM, the director of nursing indicated the resumption was late because they were not notified of the patient's return home from the hospital.</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on record review and interview, the agency failed to ensure a comprehensive discharge assessment was completed for 1 of 1 discharged records reviewed (#4).</p> <p>The findings include:</p>	G 0341	<p>frames. Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment / Comprehensive Assessment. Should errors continue staff will be counseled.</p> <p>3. The Administrator and Clinical Manager are responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p> <p>4. Correction Date: 08/18/17</p> <p>1)Licensed professionals (RN, PT, OT, ST) will be reeducated on requirements to ensure comprehensive discharge assessment.</p> <p>2)All discharged patient records beginning 08/04/17 will be audited x3months and then 10% completed quarterly.</p>	08/18/2017

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	<p>1. A review of clinical record #4 on 6/12/17 failed to show a completed discharge assessment occurred. This was evidenced by the following:</p> <p>A. A review of a document titled "Discharge Summary" dated 6/5/17 completed by Employee A, Physical Therapy, evidenced the patient had been discharged. The reason for discharge was care completed. This document stated, "Discharge diagnosis: unsteady gait, muscle weakness ... care summary PT treatment included gait and balance training, endurance, strengthening and Home Exercise program instruction reason ... patient lives in apartment in independent living facility, walks with rollator, uses supplemental O2, is alert and oriented. Discharge disposition self. Discharge instructions continue to Home Exercise Program."</p> <p>2. During an interview on 6/12/17 at 11:30 AM, the director of nursing indicated the patient had been discharged and the discharge assessment was not completed.</p> <p>3. A review of "Verification of Physician Orders Plan of Care Update" dated 6/5/17 stated, "[Physician's name and fax number] patient name [patient #4]..."</p>		<p>3) Administrator and Clinical Manager (DON) are responsible. 4) 08/18/17.</p>	

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N 0000  Bldg. 00	<p>Medicare for certification period of 4/7/17 - 6/5/17 written communication with physician: Physician response required ... Update of outcome goals ... patient has met PT goals and appears to be at maximum rehab potential ... patient is being discharged from agency at this time." This was signed by Employee A, PT.</p> <p>This was a state relicensure survey and complaint investigation survey. This survey was fully extended on 6/15/17.</p> <p>Survey dates: 6/8/17 - 6/19/17</p> <p>Complaint #: IN00232243 - Substantiated: Federal deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 003800</p> <p>Medicare #: 157562</p>	N 0000		

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N 0449 Bldg. 00	<p>Unduplicated 12 month census: 118 patients</p> <p>Active Patients: 55</p> <p>410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on home visit observation, record review and interview, the administrator failed to protect the patient's right to understand the care to be provided by the agency for 8 of 12 records reviewed ( # 1, 2, 4, 5, 6, 9, 10, 11), failed to evidence an accurate home visit schedule for 1 of 1 agency, and failed to evidence patients received therapy services inside the patients' place of residence for 8 of 12 records reviewed (#1, #2, 3, 4, 5, 6, 9, 11).</p> <p>The findings include:</p> <p>1. Regarding the patient's right to have knowledge of being a patient of the home health agency and</p>	N 0449	<p>1)Understanding that based on the recent state survey the administrator failed to ensure the Home Health Agency met the rules for licensure BHA has developed the following Plan of Correction which is designed to meet compliance as outlined in N494, N502, N504, N505:</p> <p>A. Agency will revamp patient Start of Care/ Admission Folder to stress Home Health Admission with BHA (Back Home Again), Patient Rights and Advance Directives. A copy of all forms returned to the agency will be left with the patient.</p> <p>B. The Agency will ensure each patient has ready access to file a complaint with the department by having the phone numbers (and hours of operation) to register a complaint included on the label</p>	08/18/2017	

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	<p>receiving/understanding the patient rights documents prior to the start of care:</p> <p>A. A review of the agency admission booklet titled "Back Home Again Patient Orientation for Home Health Care" dated 3/17 stated, "Section III. Patient Rights and Responsibilities" stated, "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 promote the exercise of these rights and shall do the following: Provide the patient with a written notice of the patient's rights. [A] in advance of furnishing care to the patient or [B] during the initial evaluation visit before the initiation of treatment ... You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct. To have ethical issues addressed, and inform you of standards of conduct ... choose your health care providers and communicate with those providers."</p> <p>B. A review of the undated agency admission folder titled "Back Home Again ... Patient Orientation and Information" evidenced the admission booklet in finding #1 above.</p> <p>C. A review of clinical record #1, #2,</p>		<p>for the Start of Care/ Admission Folder to BHA as well as on a magnet that will be placed on the patients' refrigerator at admission.</p> <p>C. In addition to measures to be completed per N 494 the agency will ensure all patients are informed in writing at admission of the disciplines that will provide care during the Home Health Episode and each clinician is to outline the anticipated frequency of visits for the patient.</p> <p>D. In addition to measures to be completed per N 494 all patients will be informed in advance about participating in their plan of care by having visits identified in advance on a calendar provided in the Start of Care/ Admission Folder and reminder cards distributed by the clinician for the next anticipated visit.</p> <p>2) Specific review and audits as outlined in the Plan of Correction for each N tag N494, N502, N504, N505.</p> <p>3) Administrator is responsible.</p> <p>4) Date of Compliance to be 08/18/17.</p>	

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	<p>#4, #5, #6, #9, #10, and #11 evidenced the patient's signatures on the admission document which stated, "This form is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval. Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities [including OASIS rights] and I understand them. These signatures were dated at the start of care. Refer to N494, N502, 504, and N505.</p> <p>D. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding their care. To protect and promote the exercise of the client's rights ... Special Instructions 1. A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation</p>			

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	<p>visit before treatment is initiated."</p> <p>2. Regarding accurate skilled nurse documentation for initial / re-assessments (Refer to N540/N541)</p> <p>3. Regarding an inaccurate home visit schedule "</p> <p>A. A review of the agency skilled nurse visit schedule on 6/9/17 at 9 AM failed to evidence a skilled nurse visit occurred with patient #2. This is evidenced by the following:</p> <p>i. A document titled "Column Appointments" with a date of 6/9/17 evidenced a 9 AM agency appointment scheduled with Employee B, RN. This visit did not occur as listed on the home visit calendar.</p> <p>ii. During a home visit observation of a home health aide for patient #2, on 6-9-17 at 9:00 AM, patient #2 was observed to have a home visit with Employee O, Home Health Aide.</p> <p>iii. During an interview on 6/19/17 at 5:40 PM, the director of nursing and the pending administrator indicated the schedule is constantly changing.</p>			

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	<p>4. Regarding therapy occurring in a therapy rehab room outside the patient's residence in assisted living / independent living facilities:</p> <p>A. A review of clinical records and interviews with patients evidenced the patient received therapy in the "rehab room" and not in the patient's place of residence or home. This was evidenced by the following:</p> <p>i. During a phone interview on 6/11/17 at 6:40 PM, patient #11 indicated receiving physical therapy services in a rehab room. Patient #11 indicated no other services have occurred besides this therapy which is mostly posture training.</p> <p>ii. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>iii. During a phone interview on 6/11/17 at 7:10 PM, Patient #4 indicated being completely independent with all personal care and attending therapy in a therapy room and that now rehabilitation is finished. Patient #4 indicated that</p>			

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	<p>working on strength and endurance. Patient #4 indicated being told that therapy care was on inactive list due to a report needing to be sent in and approved for her / him to continue with care.</p> <p>a. A review of a COTA visit dated 5/11/17 stated, "Pt completes 3 minutes of forward propulsion on BUE Bike, takes short rest break then completes 3 minutes backward."</p> <p>iv. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>v. During an interview on 6/13/17 at 8:50 AM, patient #13, informal caregiver of patient #3 indicated that scheduling cards were placed in the patient's door the evening before therapy. That was how the patients knew when therapy would be. Patient #13 indicated attending physical therapy in the rehab room.</p> <p>a. A review of a treatment note: Occupational Therapy completed</p>			

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	<p>by Employee E, Certified occupational therapy assistant visit dated 3/22/17 stated, "Pt completes 10 minutes Nu Step machine."</p> <p>b. A review of a COTA (certified occupational therapy assistant) visit dated 5/22/17 completed by Employee E, COTA stated, "Pt completes X 10 minutes of Nu - Step machine."</p> <p>c. A review of the clinical record #3 evidenced a treatment note: physical therapy completed by Employee C, PTA (physical therapy assistant). This note stated, "Pt warmed up on Nu - Step machine."</p> <p>d. A review of the clinical record #3 evidenced a physical therapy revisit note dated 5/8/17 with a time of 10:15 AM which stated, "Seated Standing exercises Nu - Step machine performed." This was completed by PTA, Employee C.</p> <p>vi. During an observation of a physical therapy rehabilitation room on 6/13/17 at 9:38 AM, approximately 15 patients were observed to be seated on bikes and other equipment. This observation was at an independent living / assistant living / memory care facility with Employee A, physical therapist,</p>			

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	<p>accompanying.</p> <p>vii. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated having physical therapy and occupational therapy in therapy room. She did not recall meeting a nurse from the agency.</p> <p>viii. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient was alert and oriented X 3 and not aware of patient's home bound status.</p> <p>ix. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>a. A review of the clinical record #1 evidenced a physical therapy</p>			

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	<p>visit on 13:33 PM and evidenced the patient completes 10 minutes of Nu-Step machine.</p> <p>b. A review of the clinical record #1 evidenced that on 5/25/17 at 2:10 PM at a physical therapy assistant visit evidenced the patient warmed up on a Nu - Step machine.</p> <p>c. A review of the clinical record #1 evidenced that on 6/1/17 at 1:36 PM at a physical therapy assistant visit evidenced the patient did exercises on a Nu - Step machine.</p> <p>x. During an interview with the alternate administrator / director of nursing on 6/15/17 at 11:40 AM, the alternate administrator / director of nursing indicated acknowledgement of concern that the patients had not received the admission booklets / patient rights documents and were not involved in planning their care and were receiving scheduling notes in their doors the evening before the therapy rehab room visits.</p> <p>5. The undated agency policy titled "Therapy Services" stated, "Therapy Services are an integral part of the interdisciplinary scope of services offered by the agency. Therapist shall provided</p>				

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	<p>services as determined by assessments and as per physician orders. Purpose To provide optimum quality care to patients, To provide guidelines for therapy services and care coordination with other disciplines, To comply with state / federal guidelines. Special Instructions 1. Referrals to the agency for therapy services [Physical, Speech, Occupational] my include, but are not limited to: a. Observation and evaluation b. Teaching and Training c. Direct therapy procedures d. Overall development of an individualized therapy program under the direction of the physician ... 4. If therapy services are ordered at the start of care when nursing is doing the initial assessment, therapy will do the initial assessment within 5 days of start of care or document need for other schedule. The 2011 Home Health PPS rule clarified policies regarding coverage of therapy services to assist agencies and curb misuse of benefit. The rule requires the following: 5. Measurable treatment goals be described in the plan of care and the patient's clinical record would demonstrate that the method used to assess a patient's function would include objective measurement or progress towards goals and / or therapy effectiveness."</p> <p>6. The undated agency policy titled</p>			

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	<p>"Client Admission Process" stated, "Special instructions 1. Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include a. The client / caregiver has an acceptance of home care b. The client / caregiver's ability and willingness to provide interim care, when necessary. c. The home environment is suitable or adaptable for proper home care. d. The client's needs can safely and adequately be met at the home. This includes the ongoing availability of personnel and equipment and a plan to meet medical emergencies ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine the eligibility for the Medicare home health benefit ... the admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedure for filing a complaint. This includes the Statement of Privacy Rights related to the collection and transmission of personal health care information."</p> <p>7. The undated agency policy titled "Statement of Responsibility: Administrator" stated, "In compliance</p>			

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	<p>with established policy, and in the event that the administrator: [Employee H] is not available, the designated, qualified back up: [Employee G] will assume the duties of administrator ... The administrator and designated back up shall comply with accepted professional standards and principles that apply to professionals providing home care services." This was signed by Employee G and Employee H on 4/5/17.</p> <p>8. The undated agency policy titled "Services Provided" stated, "Agency will also provide Physical, Occupational, and Speech Therapy on a visiting basis to clients in their place of residence."</p> <p>9. The undated agency policy titled "Admission Process" stated, "Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by agency in the client's place of residence."</p> <p>10. A review of a document titled "Position: Administrator" signed by the pending administrator and dated 6/16/17 stated, "Position Summary Plans, develops, and directs the programs, services, activities and employees of the agency ... Essential functions ... plans,</p>			

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N 0454 Bldg. 00	<p>organizes and directs the agency ongoing functions. 3. Directs and coordinates the overall development and administration of the agency consistent with agency mission and available resources ... assures compliance with federal / state regulations governing home health care services."</p> <p>15. During a home visit observation of a home health aide for patient #2, on 6-9-17 at 9:00 AM, patient #2 stated most of the agency provided physical therapy and occupational therapy visits had occurred on the 2nd floor therapy room, referred to as "the gym," rather than patient #2's place of residence on the 3rd floor.</p> <p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to: (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and</p>				

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	<p>(4) resolve issues; within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on record review and interview, the agency failed to ensure it appointed a qualified registered nurse for the alternate supervising nurse position for 1 of 1 agency.</p> <p>Findings include</p> <p>1. A review of the agency documents failed to evidence the appointment of a qualified alternate nursing supervisor after the resignation of Employee AA, resignation 4/14/17. The agency had documentation for a pending candidate, Employee I, Registered Nurse. The dates of employment evidenced on the resume did not correspond to dates of employment evidenced below (see #5 ). A job description obtained from a previous employer failed to evidence supervisory experience needed for the position found below (see finding #9).</p> <p>2. During an interview on 6/9/17 at 11 AM, the owner of the agency, Employee J, Physical Therapist indicated actively searching for a replacement for Employee AA since April 2017.</p> <p>A. A review of a screen shot from webmail showed email correspondence</p>	N 0454	<p>1)The administrator &amp; clinical manager/HR manager will review the hiring policies and procedures for compliance:</p> <p>A. The agency will initiate an outside source for verification of employment of all future applicants considered for open positions.</p> <p>B. Applicants will not be scheduled for orientation until the administrator has reviewed and approved an applicant for hire.</p> <p>2) HR audits of new hires to be completed by the HR manager on 100% of all new hires. This is ongoing.</p> <p>3) Administrator is responsible.</p> <p>4) Date of Compliance is 08/18/17.</p>	08/18/2017			

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	<p>concerning RN Home Health Resumes from 4/21/17 - 5/31/17 from Employee J's email. This was presented on 6/9/17.</p> <p>3. A review of a letter addressed to the program director of the Indiana State Department of Health stated, "Re: Staff change for Priority Rehab Home Health DBA Back Home Again Facility License #17 - 003800 - 1 Dear [Program Director] I am writing on behalf of staff changes for Back Home Again. Enclosed are the staff change notification forms, resumes, and criminal history checks as well as any other supporting documentation ... [Employee I, RN] will be the alternate director of nursing pending approval." This was signed by the owner, Employee J, Physical Therapist.</p> <p>4. The undated job description "C-126 Position: Alternate Director of Nursing" stated, Minimum of 2 years experience in an acute hospital setting or equivalent experience with one year of supervisory experience."</p> <p>5. A review of the resume for Employee I failed to evidence accurate dates of employment with previous employers listed on Employee I's resume. This is evidenced by the following:</p>			

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	<p>A. A review of the undated resume of Employee I evidenced employment at the Indiana State Department of Health from September 2016 - March 2017 as a Registered Nurse. Also included on this resume were the dates of October 2014 - August 2016 as a Registered Nurse. The description of this position stated, "Supervise and educate teams, confirm and develop competency, supervise 2 - 3 Licensed Practical Nurses and 25 Home Health Aides ... Monitors on - going staff development programs for nursing personnel. Also included on this resume were the dates of August 2012 - October 2014 RN at a physician office. Also included on this resume were the dates of May 2009 - August 2012.</p> <p>B. A review of Indiana State Department of Health record evidenced the dates of employment for this employee were September 2016 - January 31, 2017. The resume evidenced Employee I had worked in this role from September 2016 - March 2016.</p> <p>C. A review of an application for employment document dated 4/10/17 evidenced Employee I applied for a position of Nursing Supervisor / Contract employee.</p> <p>D. A review of an interview review</p>			

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	<p>document dated 4/7/17 and completed by the owner, Employee J, a physical therapist, evidenced Employee I was a good candidate for employment.</p> <p>E. A review of an employment reference request completed by an unknown company and dated 4/13/17 evidenced Employee I had worked for this company from 5/2009 - 10/2011. The resume evidenced employment for a nurse position from May 2009 - August 2012.</p> <p>F. A review of an employee reference request completed by the current alternate administrator / director of nursing and dated 4/14/17 evidenced the employee had worked for this home health agency from 10/2014 - 8/2016. Below is a document from that agency:</p> <p>G. A review of a document from the other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate administrator / director of nursing] 9/30/15 - 11/23/15 DON [director of nursing]."</p> <p>6. During an interview on 6/19/17 at 10:05 AM, the alternate administrator / director of nursing indicated that</p>			

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	<p>Employee I was qualified for the position and that she had given one of the two references for Employee I. She indicated working at the other agency while Employee I was in a supervisory role at the agency. She stated, "I didn't call because I was the boss at [name of the other agency]." She indicated this followed this agency's policy on checking references and verifying employment dates. She did not indicate concern that the employment date on the other reference letter varied from Employee I'S resume.</p> <p>7. During a phone interview with the administrator of the agency where Employee I had worked, the administrator of the other agency indicated that Employee I had worked at this agency from 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 and the alternate administrator / director of nursing had worked from September 30, 2015 - November 23, 2015 in the role of director of nursing.</p> <p>8. A review of a document from the other home health agency titled "Fax" dated 6/19/17 stated, "[Employee I] 10/24/14 - 10/20/15 and 1/26/16 - 8/18/16 RN Case Manager, [alternate administrator / director of nursing] 9/30/15 - 11/23/15 DON [director of</p>			

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	<p>nursing]."</p> <p>9. A review of a document from the other home health agency titled "Job Description Title of Position: Community Health Registered Nurse Title of Immediate Supervisor: Director of Nursing ... Duties of Position To provide nursing care in accordance with the client's plan of care to include comprehensive health and psychosocial evaluation, monitoring the client's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care." This job description did not show Employee I had an administrative / supervisory role in the agency. This job description was signed and dated by Employee I on 10/23/14.</p> <p>10. The undated agency policy titled "Reference Checks" stated, "The agency verifies the employment history and performance of applicants who are finalists for jobs prior to extending an offer. When a college degree or certification is a requirement of the job, reference checks may include verification of educational achievement or certification. Reference check information is used by the hiring supervisor, along with other information gathered in the selection process, to make</p>			

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	<p>a hiring decision. Procedures The candidates must have completed an application form that contains a release allowing the agency to validate information contained on the application. A standard reference form should be used. At least two references should be obtained - no more than one of them from a family member. If the candidate refuses to allow reference checks or verification of employment, advise the applicant that she or he will no longer be considered for the position. If references are questionable, work with human resources to determine whether the candidate should be considered further."</p> <p>11. The undated agency policy titled "Standard Hiring Process" stated, "The agency will establish a standard hiring process to be used for all applicants. Purpose To ensure that the process will identify any problems with employees background. Process 1. Job application a. This is the first opportunity to screen the prospective employee b. Allows the employer to obtain basic information about educational and work experiences and is the starting point of the selection process. c. Application must have a statement that all information is true and correct. This is important if contradicting information is discovered at a later date.</p> <p>2. Interview a. Every qualified job</p>			

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N 0494 Bldg. 00	<p>applicant should be interviewed ... 3. Background check a. Prior to conducting any background check, the employer must have a signed authorization from the applicant. b. There are five kinds of background checks that employers can conduct to verify candidate meets the expectations. i. Reference check - to verify the information the employee has provided - should be done on all applicants. ii. Criminal Background check -requirement will vary by state laws ... iii. Credit check ... iv. Drug Test ... v. Social Media and Internet check - this check should be used with caution because the employer may discover information that should not be used as a basis in hiring such as disabilities or health issues ... c. Analyze red flags. i. Reference checks can validate dates of employment and titles that were provided. Inconsistencies that cannot be explained are a warning sign. ii. Interviews - applicant must be able to explain gaps in employment and why they left the previous jobs listed on the application or resume."</p> <p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the</p>			

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	<p>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:</p> <p>(1) Provide the patient with a written notice of the patient's right:</p> <p>(A) in advance of furnishing care to the patient; or</p> <p>(B) during the initial evaluation visit before the initiation of treatment.</p> <p>(2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure the patient was provided a written notice of the patient rights in advance of furnishing care to the patient for 8 (# 1, 2, 4, 5, 6, 9, 10, 11) of 12 records reviewed.</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient</p>	N 0494	<p>1) The agency will revamp patient Start of Care/ Admission Folder to stress Home Health Admission with BHA (Back Home Again), Patient Rights, Oasis rights, the ISDH Hot line number and Advance Directives. A copy of all forms returned to the agency will be left with the patient.</p> <p>A. All staff to be re-educated on the Client Admission Process and informing patient of a Home Health Admission with BHA and explanation of the content within the admission folder.</p> <p>B. The new SOC packet will clearly identify BHA on the documentation being left with the patient in their home.</p> <p>C. Whenever possible all Start of Care/Admission Folders are to be placed on top of patients' refrigerator for consistent location/access.</p> <p>D. Every visit staff will remind the patient that their visit is for</p>	08/18/2017

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	<p>[including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient</p>		<p>their Home Health admission with BHA and document in the patient note.</p> <p>E. Each visit with a patient is to be signed on a paper tracking log that clearly states patient is aware they have completed a visit for Home Health Care with agency BHA.</p> <p>F. Rights will be given before care is initiated.</p> <p>G. Home Health Agency Care will be provided in the patients' residence.</p> <p>2) Chart Audits for items C, D &amp; E to be completed on new admissions beginning after 08/04/17 with the new SOC packets. The audits will be for 3 months &amp; then 10% with quarterly audits.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/18/2017</p>				

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	<p>did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights</p>			

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	<p>from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and</p>			

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	<p>explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I</p>			

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	<p>understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. Regarding patient # 10 who did not receive an admission folder until the day before the home visit observation:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient</p>			

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	<p>[including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>7. Regarding patient # 11 who did not receive an admission folder until day of home visit observation:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and</p>			

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	<p>explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>C. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>8. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic</p>			

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	<p>services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill</p>			

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	<p>of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>9. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial</p>			

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	<p>evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>10. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p>			

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	<p>11. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>12. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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</p>			

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	has complied with the requirements of this section. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the			

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	<p>home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>13. Regarding patient #2:</p> <p>A. A review of Clinical Record #2 evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in</p>			

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N 0502 Bldg. 00	<p>selecting a home health agency."</p> <p>B. During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence written notice of patient's rights to include OASIS rights. Patient #2 stated not having discarded agency documents provided at the start of care and could not recall the name of the clinician who came to the home on 2-16-17.</p> <p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health and the hours of its operation for 8 of 12 patients (#1, #2, #4, #5, #6, #9, #10, #11) prior to start of care.</p> <p>The findings include:</p> <p>1. A review of the agency admission</p>	N 0502	<p>1) The Agency will ensure each patient has ready access to file a complaint with the department by having the phone numbers (and hours of operation) to register a complaint included on the label for the Start of Care/ Admission Folder to BHA as well as on a magnet that will be placed on the patients' refrigerator at admission.</p> <p>A. Staff will be educated on the admission process and the importance of explaining the</p>	08/18/2017

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	<p>booklet titled "Back Home Again Patient Orientation for Home Health Care" dated 3/17 stated, "Section III. Patient Rights and Responsibilities" stated, "You also have the right to ... be advised of the availability of the toll free home health agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's Toll free hotline number is 1 - 800 - 227 - 6334."</p> <p>2. A review of the undated agency admission folder titled "Back Home Again ... Patient Orientation and Information" evidenced the admission booklet in fining #1 above.</p> <p>3. A review of the admission consent evidenced the following statement: "This form is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval. Patient Rights and Responsibilities I acknowledge receipt of</p>		<p>patient rights and where to locate numbers to call if a patient has a complaint.</p> <p>B. New labels will be made for the Start of Care/Admission Folders and distributed to current patients along with the magnets. Extra magnets to always be available to replace if one is discovered missing with follow up visits. The magnet will contain information for how to contact the agency administrator, Clinical Manager, as well as the hotline number and hours for the ISDH.</p> <p>2) Clinical Manager will review/audit all SOC documentation and processes to ensure patient rights are explained. Calls will be made to patients to ensure item B is understood by the patients. A telephone call will be made to the patients' home within one week of admission to ensure they understand where to locate the number call for a complaint. Call to be documented in patient chart under patient communication. This will be audited for 100% compliance after 8/4/17 x 3 months then 10% quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/18/17.</p>	

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>4. A review of clinical records # 1, 2, 4, 5, 6, 9, 10, and 11 evidenced signed consents on the start of care date. Interviews and observations below evidence the lack of knowledge that the patients had concerning the Indiana Department of Health Hotline number:</p> <p>5. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of</p>			

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	<p>operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>6. Regarding patient #4 who was not</p>			

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	<p>aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to</p>			

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	<p>send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>7. Regarding patient #5 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p>			

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	<p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>8. Regarding patient #6 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>9. Regarding patient # 9 who was not aware of being a patient of the home health agency or aware of the patient rights:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and</p>				

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	<p>explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>10. Regarding patient # 10 who did not receive an admission folder until the day before the home visit observation:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of</p>			

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	<p>operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>11. Regarding patient # 11 who did not receive an admission folder until day of home visit observation:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency</p>			

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	<p>has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>C. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for the agency in her / his possession.</p> <p>12. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The</p>			

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	admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice			

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	<p>identifying when orders for services will not be covered by the Medicare benefit.</p> <p>K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>13. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of</p>			

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	<p>Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>14. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>15. The undated agency policy titled "Advance Directive Procedure" stated,</p>			

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	<p>"The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p> <p>16. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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. b. The patient has the right to exercise his or her rights as a patient of</p>			

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	<p>the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive</p>			

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	<p>complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p> <p>17. Regarding patient #2:</p> <p>A. A review of Clinical Record #2 evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p>			

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N 0504 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 record review and interview, the agency failed to ensure that the patient was informed in advance about the care to be furnished by the home health agency in 5 of 12 records reviewed (# 1, 4, 5, 6, 9).</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of receiving care from the agency:</p>	N 0504	<p>1) In addition to measures to be completed per N 494 the agency will ensure all patients are informed in writing in advance of providing services at admission and as an ongoing procedure of the disciplines that will provide care during the Home Health Episode and each clinician is to outline the anticipated frequency of visits for the patient. Should changes need to be made to established Plan of Care patient will be notified in writing prior to providing care.</p> <p>A. Staff will be educated on communicating anticipated frequency with their patients and</p>	08/18/2017

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	<p>A. A review of Clinical Record #1 evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p>		<p>documenting on a calendar to be left in the admission folder in the patients' home. This includes revisions/updates to the Plan of Care involving disciplines and frequencies recorded on the patient calendar in their admission folder.</p> <p>B. The revamped Start of Care/Admission folder will include blank calendars as well as a checklist of items (left in the home and returned to the office) that includes calendars and patient acknowledgement of calendar.</p> <p>C. Patient will be notified in writing of any changes in disciplines and / or frequency recorded on the patient calendar in their admission folder.</p> <p>2) The Clinical Manager will review/audit all new SOC documentation for compliance of items B &amp; C. This will be audited for 100% compliance after 8/4/17 x 3 months then 10% quarterly.</p> <p>3) Administrator Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance is 08/18/17.</p>				

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	<p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of receiving care from the agency:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated</p>			

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	<p>being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of</p>			

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	<p>my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission</p>			

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	<p>consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or receiving care from the agency:</p>			

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	<p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by</p>						

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	<p>which a client can be deemed appropriate for admission. These standards include:</p> <p>a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ...</p> <p>9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative</p>			

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	<p>associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>7. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood</p>			

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	<p>by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive</p>			

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	<p>questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider ... when the client / caregiver has reviewed the Bill of Rights and their right to complain to the agency, they are also given the numbers and contact information for the Home Care Hotline operated by the Department of Health."</p> <p>8. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>9. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is</p>						

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	<p>provided: The agency policies on advance directives."</p> <p>10. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable</p>			

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	<p>discharge notice ... 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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told</p>			

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N 0505 Bldg. 00	<p>what to do in case of emergency."</p> <p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on record review and interview, the agency failed to ensure that the patient was informed in advance about the right to participate in the planning of care to be furnished by the home health agency in 5 of 12 records reviewed (# 1, 4, 5, 6, 9).</p> <p>The findings include:</p> <p>1. Regarding patient #1 who was not aware of being a patient of the home health agency or aware of receiving care from the agency</p> <p>A. A review of Clinical Record #1</p>	N 0505	<p>1) In addition to measures to be completed per N 494 all patients will be informed in advance about participating in their plan of care by having visits identified in advance on a calendar provided in the Start of Care/ Admission Folder and reminder cards distributed by the clinician for the next anticipated visit. A. Staff will be educated on utilization of the calendar and distribution of reminder cards. If a reminder card is distributed it is to be documented in the patient note. 2) The agency will contact patient the day before the next scheduled visit to remind them of</p>	08/18/2017

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	<p>evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p>		<p>their next scheduled visit. A log of daily contact will be kept at the agency and these will reviewed weekly by the clinical manager for 100% compliance x 3 months then 10% quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance is 08/18/17.</p>	

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	<p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>2. Regarding patient #4 who was not aware of being a patient of the home health agency or aware of receiving care from the agency</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab</p>			

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	<p>room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>3. Regarding patient #5 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I</p>			

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	<p>understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>4. Regarding patient #6 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and</p>			

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	<p>Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>5. Regarding patient # 9 who was not aware of being a patient of the home health agency or receiving care from the agency:</p> <p>A. A review of Clinical Record #9 evidenced the patient started care with</p>			

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	<p>the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>6. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include:</p>			

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	<p>a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ... 9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client /</p>			

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	<p>caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>7. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To</p>			

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	<p>protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be</p>			

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	<p>informed of their right to voice a grievance without fear of retaliation from the provider ... when the client / caregiver has reviewed the Bill of Rights and their right to complain to the agency, they are also given the numbers and contact information for the Home Care Hotline operated by the Department of Health."</p> <p>8. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>9. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is provided: The agency policies on advance directives."</p>			

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	<p>10. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights and shall do the following: 1. Provide the patient with a written notice of the patient right's 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. b. The patient has the right to exercise his or her rights as a patient of the home health agency as follows: The patient's family or legal representative may exercise the patient's rights as permitted by law. 2. The patient has the right to ... D. Be informed about 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] changes in the care or treatment [iii] the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice ... the home health agency must inform and distribute written</p>			

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	<p>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 advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. You also have the right to ... have a relationship with our staff that is based on honesty and ethical standards of conduct ... be advised of the availability of the toll - free Home Health Agency [HHA] hotline in the state. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the state, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll free hotline number is 1 - 800-227-6334. The hotline number is available 24 hours a day, seven days a week ... accept or refuse care, treatment, and / or services without fear of reprisal or discrimination ... receive care of the highest quality ... be admitted only if we can provide the care you need ... be told what to do in case of emergency."</p>			

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N 0518 Bldg. 00	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives in 8 (# 1, 2, 4, 5, 6, 9, 10, 11) of 12 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of Clinical records #1, 4, 5, 6, 9, 10, 11 failed to evidence the most current version of the description of Indiana state law regarding advance directives, "Your Right To Decide", dated July 2013, had been provided to the patients at the start of care. This is evidenced by the following:</li> <li>2. A review of the admission handbook for the agency titled "Back Home Again</li> </ol>	N 0518	<p>1) The Agency will ensure that patients receive the most current description of the Indiana State Health Department Advance Directives (Revised July 1, 2013) in the revamped Start of Care/ Admission folder.</p> <p>A. Admitting and all clinical staff to be educated on the most current version of Advance Directives so they may ensure patient has the most current version.</p> <p>B. Extra copies of the most current version of Advance Directives (Revised July 1, 2013) to be distributed to have on hand to give to patients if outdated versions are identified in current patient homes.</p> <p>C. The primary professional in the home is to review at recertification the advance directive in the home and document findings in their clinical note.</p>	08/18/2017

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	<p>Inc Home Health Care Services ... Patient Orientation &amp; Information" included the Indiana State Department of Health Advance Directives Your Right to Decide Revised May 2004.</p> <p>3. A review of the "Back Home Again Patient Orientation for Home Health Care" dated 3/17 included a section titled "Section III: Patient Rights and Responsibilities" stated, "The patient or the patients 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 ... The patient has the right to be as follows ... the home health must inform and distribute written information to the patient in advance concerning its policies on advance directives, including a description of state law. The home health agency may furnish advance directive information to a patient at the time of the first home visit, as long as the information is furnished before care is provided."</p> <p>4. Regarding patient #1 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #1</p>		<p>2) The Clinical Manager will review the SOC checklist for receipt of the updated Advance Directives as well as audit recertification for inclusion of documentation of Advance Directives in the patient home with quarterly chart audits. Audits to be completed on 100% of new admissions 08/04/17 for 3 months and then quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance 08/18/17.</p>	

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	<p>evidenced the patient started care with the agency on 5/22/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/14/17 at 2:40 PM, patient #1 indicated not being a home health agency patient with any home health agency but being a patient of an rehabilitation company where he / she received physical therapy and occupational therapy in a wellness room. Patient #1 indicated very recently the therapists started coming to her / his</p>			

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	<p>apartment instead of his / her attending therapy in the wellness room. The patient was not aware of being with a home health agency or being informed of his / her rights as a patient of a home health agency or receiving a copy of anything including rights from a home health agency.</p> <p>C. During an interview on 6/15/17 at 3:40 PM, the director of nursing and Employee H, Registered Nurse, did not indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>5. Regarding patient #4 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #4 evidenced the patient started care with the agency on 4/7/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I</p>				

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	<p>have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ...</p> <p>Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>C. During an interview on 6/19/17 at 11:35 AM, the director of nursing did not</p>			

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	<p>indicate agreement or concern that the patient was not aware of being a home health agency patient or that the patient did not receive his / her patient rights.</p> <p>6. Regarding patient #5 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #5 evidenced the patient started care with the agency on 5/31/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for</p>			

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	<p>myself."</p> <p>B. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency.</p> <p>C. During an interview on 6/16/17 at 3:30 PM, the director of nursing indicated that the admission folder was given to the patient.</p> <p>6. Regarding patient #6 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p> <p>A. A review of Clinical Record #6 evidenced the patient started care with the agency on 3/1/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I</p>				

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	<p>have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ...</p> <p>Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During a phone interview on 6/11/17 at 7 PM, patient #6 indicated refusing home health agency care but does receive out patient therapy services from a therapy company The patient indicated this therapy occurs in a therapy room at the independent living facility where he / she lives.</p> <p>C. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated that the patient not receiving the admission folder or rights was a concern.</p> <p>7. Regarding patient # 9 who was not aware of receiving the most current description of Indiana state law regarding advance directives:</p>			

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	<p>A. A review of Clinical Record #9 evidenced the patient started care with the agency on 4/6/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time, person, and place).</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated always attending therapy in the therapy room and</p>			

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	<p>has never seen a nurse. The patient indicated not having an admission folder and not being part of any home health agency. The patient indicated that he / she would not have therapy today.</p> <p>8. Regarding patient # 10 who was not aware of receiving the most current description of Indiana state law regarding advance directives at the start of care:</p> <p>A. A review of Clinical Record #10 evidenced the patient started care with the agency on 4/21/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be</p>			

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	<p>known when I am unable to speak for myself."</p> <p>B. During an interview on 6/13/17 at 2:50 PM, patient #10 indicated receiving admission folder booklet yesterday.</p> <p>C. During a home visit observation on 6/13/17 at 2:50 PM, patient #10 was observed to have an admission folder for the agency in her / his possession.</p> <p>9. Regarding patient # 11 who did not receive an admission folder until day of home visit observation or have knowledge of advance directives:</p> <p>A. A review of Clinical Record #11 evidenced the patient started care with the agency on 5/24/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the</p>			

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	<p>Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p> <p>B. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights ... You also have the right to ... receive information in a manner you can understand ... be advised of the availability of the toll free home health agency [HHA] hotline in the state."</p> <p>C. During an interview on 6/13/17 at 11:20 AM, patient #11 indicated receiving admission folder booklet today and not having the booklet including the patient rights before today.</p> <p>D. During a home visit observation on 6/13/17 at 11:20 AM, patient #11 was observed to have an admission folder for</p>			

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	<p>the agency in her / his possession.</p> <p>10. The undated agency policy titled "Client Admission Process" stated, "Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include:</p> <p>a. The client / caregiver has an acceptance of home care ... 7. Each client referred to the agency shall be evaluated by a Registered Nurse / Therapist to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for the Medicare home health benefit ...</p> <p>9. The evaluating may be made upon the initial admission visit if the physician's order is assessment. A physician's order for skilled nursing and / or therapeutic services must be obtained from the client's physician before the initial assessment visit is made. 10. The admission professional will ... provide the client / caregiver with a copy and an explanation of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the statement of Privacy Rights related to the collection and transmission of personal health care information. d. Complete the assessment form, including OASIS data elements, Plan of Care / 485, Care plan if indicated, medication regime review, and additional documents, as</p>			

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	<p>required ... f. Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible. Inform the client / caregiver of any reasonable risk and / or alternative associated with any procedure provided in the home. g. advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care. i. Obtain the client's signature on the service agreement, Home Care Bill of Rights, and other forms required by the agency. j. Provide the client / caregiver Advance Beneficiary Notice identifying when orders for services will not be covered by the Medicare benefit. K. Inform adult clients of their right to formulate advance directives and explain the agency policy regarding advance directives."</p> <p>11. The undated agency policy titled "Home Care Bill of Rights" stated, "Clients will be informed of their rights as a consumer of home care services. This includes the right to voice</p>			

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	<p>grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Purpose: To consistently inform clients verbally and in writing, or by other means understood by the clients, of their right to make informed decisions regarding care. To protect and promote the exercise of client's rights. To establish, operate, and maintain a grievance /complaint mechanism for use by the client / representative, which assures response and disposition and is in operation at a minimum during business hours. Special Instructions: A designated Registered Nurse / Therapist shall provide the client with a written notice of the Home Care Bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented. a. Clients / families will be informed of their to privacy and confidentiality related to personal health care information data collection and transmission [OASIS]. The client / caregiver shall be advised orally and in writing of their right to voice grievances and the method of contacting the agency</p>			

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	<p>if dissatisfied. This shall include information about the Home Health agency hotline [established by the state] including its hours of operation and that the purpose of the hotline is to receive questions or complaints about local home health agencies. Clients should be informed of their right to voice a grievance without fear of retaliation from the provider."</p> <p>12. The undated agency policy titled "Advance Directive Policy" stated, "Agency recognizes the importance of clients participate in planning care and of their right to accept or refuse treatment. Agency will provide all clients with the agency's advance directives policy before the start of care."</p> <p>13. The undated agency policy titled "Advance Directive Procedure" stated, "The organization recognizes that all persons have a fundamental right to make decisions relating to their own care, treatment, and services including the right to accept or refuse medical care. Valid advance directives will be followed to the extent permitted and required by law ... During the admission process, the Registered Nurse / Therapist shall provide the client with the following written information. This information must be given to the client before care is</p>			

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	<p>provided: The agency policies on advance directives."</p> <p>14. Regarding patient #2 who did not receive the advance directives in the admission folder:</p> <p>A. A review of patient #2's clinical record evidenced the patient started care with the agency on 2/16/17. An admission consent was signed on this date. This document stated, "Patient Rights and Responsibilities I acknowledge receipt of my rights and responsibilities as a patient [including OASIS rights] and I understand them. The state hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency ... Advance Directives I understand that the Federal Self - Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself."</p>			

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	<p>B. The agency booklet titled "Patient Orientation for Home Health Care" dated 3/17 included "Section III. Patient Rights and Responsibilities Sec. 3. [a] The patient or the patient's legal representative has the right to be informed of the patient's rights through effective communication. The home health agency must protect and promote the exercise of these rights ... You also have the right to ... receive information in a manner you can understand ... be advised of the availability of the toll free home health agency [HHA] hotline in the state."</p> <p>C. During home visit observation of a home health aide of patient #2, on 6-9-17 at 9:00 AM, with permission, patient #2's admission folder was reviewed. The folder had a taped on printed drawing of a bird on the front, and underneath observed was "Back Home Again." Patient #2 identified the folder as the Back Home Again admission folder. Review of the folder failed to evidence written notice of a description of applicable Indiana Advance Directive law; and failed to evidence documentation of the agency's policies related to advance directives had been provided. Patient #2 stated not having discarded any documents from the admission folder and could not recall the</p>				

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N 0520 Bldg. 00	<p>name of the clinician who visited the home on 2-16-17, when admission procedures were accomplished. Review of a consent, "Admission Consent," dated 2-16-17, evidenced patient #2 had checked the boxes indicating having a living will and durable power of attorney as advance directives. Patient #2 stated not having provided copies of the documents to the agency, and not having been asked by any agency personnel to provide a copy of the 2 advance directives to the home health agency. Patient #2 denied anyone from the agency had explained the agency's policies related to Advance Directives.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the</p>			

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	<p>home health agency in the patient's place of residence.</p> <p>Based on home visit observation, record review and interview, the agency failed to ensure patient needs were addressed and being met adequately in the patient's place of residence for 1 of 12 records reviewed (#3).</p> <p>The findings include:</p> <p>1. A review of Clinical record #3, start of care 3/6/17, failed to evidence the patient's needs were met. The patient had ongoing severe pain issues and constipation issues since a fall documented 5/26/17 with T 12 compression fracture diagnosis after an emergency room visit. The patient's record included a "Home Health Certification and Plan of care" dated 5/4/17 and signed by the physician on 5/22/17. The patient was being seen by the Skilled Nurse for ongoing education on disease processes and medications. Physical and occupational therapy for lower extremity strengthening, transfer training and standing balance. The patient made plans to discharge from the agency on 6/15/17 and transfer to a rehabilitation skilled facility due to the ongoing pain concerns. There was no detailed communication showing discussion between the physician,</p>	N 0520	<p>1) The agency will only accept patients when the patients' health needs can be adequately met by the home health agency in the patients place of residence. If the established plan of care is ineffective and not met within the agencies parameters a referral will be made to an alternate provider.</p> <p>A. All staff to receive reeducation of home health admission/CMS standards and coordination of care with documentation between team members, physicians and outside facilities if a patient is transferred out of care.</p> <p>B. All direct care staff to receive education and training on patient medical plan of care, pain management with documentation and coordination of services as well as medication management with documentation and coordination of services.</p> <p>C. All direct care staff to receive education and training on patient safety as well as identification to prevent potential adverse events.</p> <p>2) The Clinical Manager will include A, B &amp; C in new employee orientation as well as annually for all direct care staff. HR charts audited for compliance annually with review and re-mediated for 100% compliance within 30 days of annual review. 100% of patient records admitted after 08/04/17 will be audited x 3 months then</p>	08/04/2017

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	<p>physical therapist, skilled nurse, and occupational therapy about what medications the patient was taking and if any relief was occurring with specific pain medications or a plan to manage this severe pain. The plan of care and updates to the plan of care were not updated to show a pain management plan on the plan of care. This is evidenced by the following:</p> <p>A. A review of a 5/26/17 RN - Skilled Nursing (SN) Visit- completed by Employee B, Registered Nurse, evidenced communication between the occupational therapist and RN that the patient had fallen in the past week. The SN documented that reviewing all body systems of the patient, that the patient's pain level was a "5" on a 10 point scale with "10" being severe pain and "0" being no pain. The skilled nurse documented that the patient was taking Tylenol which had fair results.</p> <p>B. A review of an emergency room discharge disposition evidenced the patient was treated in the emergency room for a compression fracture. This was dated 5/27/17.</p> <p>C. A review of a PT re - evaluation visit completed by Employee B, PT, dated 5/30/17 evidenced patient reported</p>		<p>10% quarterly for coordination of care, pain management, making changes to the POC for patient changes in condition and identifying adverse events. Should errors continue staff will be counseled.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of compliance to be 08/04/17.</p>	

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	<p>a fall and complaint of lower back pain since that fall.</p> <p>D. A review of a OT Re- evaluation visit completed by Employee D, OT, and dated 5/30/17 evidenced this statement: "Pt reports falling within past week. Pt was taken to hospital c /o lower back pain however no major injury."</p> <p>E. A review of a 6/1/17 note titled "OASIS C2 Transfer" evidenced the patient had transferred to an inpatient facility due to injury caused by fall. The transfer had occurred on 5/31/17. This document was completed by Employee B.</p> <p>F. A review of a procedure dictation document for a procedure 5/31/17 evidenced the patient had a T 12 compression fracture. The patient had lidocaine patches to apply. The patient reported increasing pain at a "9 - 10" level.</p> <p>G. A review of the record evidenced a resumption of care assessment dated 6/5/17 after a patient's return from an inpatient hospital stay. The pain portion of this assessment evidenced the patient's pain was a level 8 with constant duration with throbbing quality and any movement makes the pain worse. What makes pain</p>				

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	<p>better is medication, relaxation, decreased movement. The medications weren't documented and the patient's pain goal was not documented. There were no goals documented for decreased pain. This document stated, "had fall while out of town, returned home then went to ED [emergency department] for worsening pain. It was determined [patient] had fx at T 12. Physician has been notified of initial assessment and tentative POC [plan of care], frequency, interventions, and goals to be documented on 485 [plan of care] and submitted for signature. Patient is agreeable to proposed POC."</p> <p>During an interview on 6/19/17 at 2:50 PM, the director of nursing indicated the resumption was late because they were not notified of the patient's return home from the hospital.</p> <p>H. A review of the medication profile dated 6/5/17 evidenced colace for constipation and no other medication to relieve constipation. Tramadol HCL oral 50 milligrams 1 tablet twice a day was ordered for pain. There were no other pain medications ordered including Tylenol except Aspirin oral 81 mg 1 tablet daily analgesics.</p> <p>I. A review of a PT (physical therapy) evaluation visit document dated</p>			

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	<p>6/6/17 signed by Employee A, Physical Therapist evidenced the patient had complained of severe pain at a level of "10" (with "0" being no pain and "10" being the most severe.) This evaluation failed to evidence a complete pain assessment. There was no description of the pain with this assessment. This document evidenced that the factor contributing functional impairment was weakness and back pain. The treatment goal was for the patient to report that back pain does not limit [his / her] ability to walk from apartment to facility dining room.</p> <p>J. A review of an OT (occupational therapy) Re-evaluation Visit document dated 6/6/17 signed by Employee D, OT evidenced the patient had complained of severe pain at a level of 10. There was no description of the pain with this assessment. The evaluation assessment summary stated, "Due to increased back pain, patient reports not leaving room for last few days for meals / going out. Pt is requiring significantly increased assistance with all self care and functional mobility tasks due to severe back pain. Pt. recently received orders from physician to wear back brace while up. Pt. requires maximum assist to don supportive back brace. Due to physical / cognitive deficits, pt's [informal</p>			

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	<p>caregiver] is unable to safely and accurately assist with back brace. Pt will benefit from continued OT focusing on increasing BUE [bilateral upper extremity] strength, activity tolerance, improving self - regulation of pain from arthritis symptoms and increasing functional transfers in order to maximum safety and independence with daily routine and functional mobility tasks."</p> <p>K. A review of the record evidenced a skilled nursing visit dated 6/7/17 signed by Employee B. The nurse documented the patient's pain level was a "6". There was also a note: "Doctor was called about pt. has been sitting in chair since Sunday and has ate / drank little, has moved infrequently, and is taking pain medication tramadol. Instructed pt on constipation prevention, hydration, movement, use of colace as ordered regularly. SN called [informal caregiver] to see what prn [as needed] medications are available to patient, instructed [informal caregiver] on constipation and pain medications effects on constipation ... called [informal caregiver] who sets up meds to see if patient had prn miralax or milk of magnesia." The physician was contacted about severe pain but not about the constipation. There were no communications with the physician confirming that the patient had prn</p>				

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	<p>miralax or milk of magnesia to help with the constipation. There were no communications in the record about what the physician communicated about the severe pain to this nurse. The time in was 10:15 AM and time out 10:46 AM.</p> <p>L. A review of a PTA visit dated 6/7/17 evidenced a therapy assistant visit signed by Employee C. The time in for this visit was 10:48 AM. Time out was 11:22 AM.</p> <p>M. A review of the record evidenced a skilled nursing visit dated 6/8/17 signed by Employee B. Patient had a small bowel movement evening before. Pain level was a "9" at this visit. The physician was not notified.</p> <p>N. A review of the record evidenced a COTA visit signed by Employee E, COTA. The pain level was not described or a severity level given. The pain was located in the lower back.</p> <p>O. A review of the record evidenced an OT visit signed by Employee D, OT. The pain level was not described or a severity level given. The pain was located in the lower back.</p> <p>P. A review of a PTA visit dated</p>			

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	<p>6/9/17 evidenced a therapy assistant visit signed by Employee C.</p> <p>Q. A review of the record evidenced a PTA visit signed by Employee C, PTA dated 6/12/17 with patient complaints of severe pain at a "9" level. This visit was communicated with Employee A, Employee B, and Employee D. The physician was not contacted.</p> <p>R. A review of the record evidenced a OT visit signed by employee D, OT, on 6/12/17. The patient's pain was located in the lower back but not described further.</p> <p>S. A review of the record evidenced a RN - Skilled Nursing Visit completed by Employee B, RN on 6/12/17 The patient had a pain level of a 10. This document was missing pages 3 and 4.</p> <p>T. A review of the record evidenced a physical therapy visit dated 6/13/17 signed by Employee A. The physical therapist documented that the patient complained of severe pain at a "11" on the "10 point scale with no relief and constipation. Physician was called with update and voicemail left. There was no communication noted with the physician at this time. Another note with this date signed by Employee A evidenced the</p>			

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	<p>patient had stated he / she would end his / her life because the pain was so severe.</p> <p>At a home visit observation on 6/13/17 at 9:05 AM with patient #3 and Employee A, physical therapist, patient #3 was observed to ambulate from the bathroom to a chair in the living room. Patient #3 was observed to complain of severe pain and lack of appetite and food intake and constipation with lack of bowel movement for 4 days. Patient #3 indicated taking pills at 8 AM including the pain medication, Tramadol. The patient indicated the pain was at a level of a "11" on a 10 point scale with no pain relief from the tramadol. Employee A asked the patient about the pain level. Employee A did not ask the patient to describe the pain. The PT took the patient's vital signs and continued with the therapy exercises including marching in place in a seated position. At 9:32 AM, Employee A was observed to leave a voice mail on the physician's phone. Employee A asked about the patient's pain level three times through the visit and the patient answered the pain was at a level of "11" each time. These questions were asked at the beginning of the visit, the middle of the visit, and at the end of the visit. The patient answered that the pain was so severe that he / she wished to end his / her life. The patient</p>			

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	<p>asked at the end of the visit, "What am I going to do about this pain?" The physical therapist said to take an ice pack and use it off and on about 20 minutes at a time for pain relief. The PT, Employee A stated, "Keep a good attitude and stay positive."</p> <p>U. A review of the patient communication note dated 6/13/17 signed by Employee E, Certified Occupational Therapy Assistant, evidenced that a canceled visit due to the patient's pain level.</p> <p>V. A review of the record evidenced the physician returned a call to the PT, Employee A, and acknowledged receipt of message about the patient's pain and that the physician is in contact with the family. This was dated and signed on 6/14/17.</p> <p>X. A review of the record evidenced a PTA (physical therapy assistant) visit dated 6/14/17 with the patient's continued report of pain of a 9 level. Exercises included hip flexion and extensions, hip abductions and adductions, internal rotation, external rotation, and knee flexions and extensions.</p> <p>Y. A review of the record evidenced a patient communication note signed by</p>			

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	<p>Employee A that the informal caregiver called to cancel PT / OT visits today since patient is anticipating moving to a rehab today. PT and OT were notified. This was dated 6/15/17.</p> <p>2. The undated agency policy titled "Client Admission Process" stated, "All services are available without distinction to all individuals, regardless of their diagnosis ... The agency determines that client needs can be met by the agency."</p> <p>3. The undated agency policy titled "Pain Assessment / Management" stated, "All clients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as treatment of efficacy of treatment. The agency will work with the client, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will be reviewed and modified if the client does not have pain relief. Poorly managed pain delays healing and recover time, alters the body's immune system and increases stress, anxiety and depression. Clients will be informed that they have the right to have pain evaluated and effectively treated. Pain will be treated as a vital sign and agency will</p>			

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	<p>strive to ensure that pain is measured and treated .... Pain assessment is an integral part of the initial comprehensive assessment and the client's right to expect appropriate assessment and management is explained and honored. If the client has pain that interferes with pain or movement on a daily basis or is determined to be intractable, pain management will be specified intervention on the plan of care ... Pain is assessed on every nurse / therapist home visit and documented on a pain or symptom flow sheet. Documentation will include the effectiveness of all pain interventions or modalities. The documentation will include what interventions were used and describe response / effectiveness of care. 4. Referrals to pain specialist and utilization of best practices will be documented if utilized. 5. The nurse / therapist will use a standardized agency accepted pain assessment tool that evaluates the locations, duration, severity [rating scale], alleviating factors, exacerbating factors, current treatment [medication and non-medication] and response to treatment. 6. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral or alternative therapy. If the established plan is ineffective and the pain management</p>			

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N 0524 Bldg. 00	<p>needs can not be met within the agency pain parameters, a referral will be made to an alternate provider. 7. Assessment of presence of pain and treatment / response will be incorporated into all agency assessment / reassessment tools."</p> <p>4. During an interview on 6/19/17 at 3:10 PM, the director of nursing stated, "We can only do what we can do."</p> <p>5. During an interview on 6/19/17 at 5:30 PM, the pending administrator indicated that the plan was to be there with patient's pain. A patient's pain level is subjective and physical therapy was the plan for pain management.</p> <p>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.</p>			

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	<p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure plans of care were complete and accurate and signed by the physician in a timely manner for 2 of 12 records reviewed (#3, #8).</p> <p>The findings include:</p> <p>1. A review of clinical record #3 included a document titled "Home Health Certification and Plan of care" for the certification period of 5/5/17 - 7/3/17. This plan of care had been signed by the Registered Nurse, Employee B, on 5/4/17 and the physician on 5/22/17. The plan of care included orders for the skilled nurse to be seen 1 times a week for 3 weeks. The plan of care stated, "[Patient's name] is being seen by SN for ongoing education on disease processes and medications. The statement on the</p>	N 0524	<p>1) The medical plan of care shall be developed in consultation with all home health agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnosis, and include key elements specific to the patient.</p> <p>A. All clinical staff involved in the assessment, evaluation and development of a medical plan of care will be educated on all required elements specific to the patient. These will include mental status, types of services and equipment required, frequency and duration, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, safety measures, instructions for discharge or referral and therapy modalities. To ensure an individualized plan of care disease processes with patient education, medications, goals</p>	08/04/2017

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	<p>plan of care did not indicated the specifics of what disease processes would be educated on.</p> <p>During an interview on 6/15/17 at 3:33 PM, the director of nursing indicated that this is a concern and is being addressed.</p> <p>2. A review of clinical record #8 with a start of care date of 6/2/17 included a "Home health Certification and Plan of Care" for the certification period of 6/8/17 - 8/6/17. This plan of care evidenced the nurse was to assess if the patient was filling the medication box to determine if patient is preparing correctly. This was not an accurate task for this plan of care. The patient's informal caregiver was filling the medication box and was not at the skilled nurse visit observed. The plan of care was not individualized for this patient. This is further evidenced by the following:</p> <p>A. During a home visit observation on 6/14/17 at 3:10 PM, Employee B was not observed to check if the patient was preparing the medication box. Employee B did not have a copy of the plan of care at the visit.</p> <p>B. During an interview on 6/14/17 at</p>		<p>and interventions are to be incorporated.</p> <p>B. Staff to be educated on timely and accurate revisions to the plan of care and subsequent care coordination with team members and physicians.</p> <p>C. A copy of the current plan of care to be available in the patients' folder in the event that a clinician is unable to access their POC electronically.</p> <p>2) 100% of all new patient records will be audited at admission and recertification for accuracy, timely revisions and coordination of care for 3 months and then 10% quarterly. Should errors continue, staff will be counseled.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance 08/04/17.</p>				

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N 0540 Bldg. 00	<p>3:30 PM, patient #8 indicated the informal caregiver was in charge of setting up the patient's medications weekly.</p> <p>C. During an interview on 6/16/17 at 3:20 PM, Employee I, RN, indicated that this task was not completed at the visit since this task was incorrectly listed on the plan of care.</p> <p>3. The undated agency policy titled "Plan of Care" stated, "Home care services are furnished under the direction of teh client's physcian. The plan of care is based on a comprehensive assessment and information rprovided by the client / family and health team members ... an individualzied plan of care signed by a physician shall be required for each client receiving home heathl and personal care servcies. The plan of care shall be completed in full to include a. all pertinent diagnosis [es] ... b. mental status c. Type, frequency, and duration of all visits / services d. Specific procedures and modalities for therapy services ... l. Medications, treatments, and procedures."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for</p>			

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	<p>purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(A) Make the initial evaluation visit. Based on home visit observation, record review and interview, the agency failed to complete an accurate initial assessment for 5 of 12 records reviewed (#1, #4, #5, #9, #11).</p> <p>The findings include:</p> <p>1. A review of Clinical record #1's record with a start of care (SOC) 5/22/17 evidenced an incomplete and inaccurate initial assessment. The patient was able to complete ADLs (activities of daily living) independently and this assessment did not show that this could occur accurately. Plus the assessment evidenced the patient had caregivers to help with these tasks but did not complete the section of supportive assistance who completed these tasks under M1100. This was evidenced by the following:</p> <p>A. A review of Clinical record #1 failed to evidence a complete and accurate OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment. There were two of these documents dated 5/22/17. One was signed by the director of nursing and the other signed by Employee B, Registered Nurse and both of these were in the</p>	N 0540	<p><b>N 540</b></p> <p>1)The agency will immediately complete an accurate &amp; comprehensive initial assessment of all patients admitted for a home health episode. Medicare patients not accepted for admission following initial assessment will receive the CMS NOMNC.</p> <p>A. All direct care staff (RN, PT, OT &amp; ST) will receive reeducation and training on completing an accurate initial patient assessment. Admitting professional shall document immediate care &amp; support needs and homebound status for Medicare. This includes skilled &amp; Paraprofessional needs. This includes coordination of care with team members to identify discrepancies in clinical data and patient criteria for admission.</p> <p>B. The agency will contract an external QA (associated with the new EMR system) to evaluate all components of the Oasis elements as well as the initial therapy evaluations to monitor for discrepancies and contraindications. Any discrepancies will be discussed in team conference. Final review and submission to be approved by the Clinical Manger or alternate. All modifications to the</p>	08/04/2017			

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	clinical record. This review occurred on 6/19/17. Both documents revealed the patient lives in a congregate situation. The section titled "M1100 ... Type of Assistance Receives - other than from home health agency staff was left blank. This included ADL (bathing, dressing, toileting, bowel / bladder, eating / feeding), IADLs (instrumental activities of daily living scale: meds, meals, housekeeping, laundry, telephone, shopping, finances), psychosocial support, assistance with medical appointments, delivery of medications, and management of finances). Under this was the name of Supportive assistance: Names of organizations providing assistance. This was left blank. Under the home bound section, a box was checked "Yes." Under this was checked a box titled "Residual weakness" and "Requires Max assistance / taxing effort to leave home and "Unable to safely leave home unassisted." The box titled "M1810 Current Ability to dress upper body safely [with or without dressing aids] including undergarments, pullovers, front - opening shirts and blouses, managing zippers, buttons, and snaps ... able to dress upper body without assistance if clothing laid out or handed to the patient ... M 1820 Current ability to dress lower body safely [with or without dressing aids] including undergarments,		original submission to be documented on a modification revision form, signed by all parties, and incorporated into the patients' chart. 2) Clinical Manager to audit B and review the initial assessment for required content and patient meeting the required elements for admission to home health prior to locking and approving the Oasis for submission to CMS. 100% of new admissions after 08/04/17 to be audited. This is ongoing. 3) The Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance is 08/04/17	

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	<p>slacks, socks, or nylons, shoes ... 2. Someone must help the patient put on undergarments, slacks, socks, or nylons, and shoes ... M 1830 Bathing Current ability to wash entire body safely ... able to bathe in shower or tub independently, including get in and out of tub / shower ... M 1840 Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode ... 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer ... Transferring ... 2. Able to bear weight and pivot during the transfer process but unable to transfer self ... GG0170C Mobility Code the patient's usual performance at the SOC / ROC using the 6 point scale ... Coding: Safety and Quality of Performance ... 03 ... Partial or moderate assistance - helper does less than half the effort. Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort ... M 1860 Ambulation / location ... able to walk only with the supervision or assistance of another person at all times ... M 2020 Management of Oral Medication ... Unable to take medication unless administered by another person ... M 2102 Types and sources of assistance ... Type of assistance ADL assistance [for example, transfer, ambulation, bathing,</p>			

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	<p>... dressing, toileting, eating / feeding) ... non- agency caregivers currently providing assistance." Also marked in the 2102 box was that the IADLs assistance was completed with assistance, medication administered by a nonagency caregiver, supervision and safety. All of this assistance was provided at least daily. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy (PT) evaluation visit completed on 5/22/17 at 3:38 PM evidenced the patient lived alone in a apartment in an independent living facility and has caregivers who assist with housekeeping and meal preparation. This was signed by Employee A, PT.</p> <p>C. A OT (occupational therapy) evaluation visit signed by Employee D, OT, dated 5/22/17 with a time of 2:50 PM stated, "Pt. ambulated with rolling walker and completed all ADL's and transfers with Mod [Modified] I / independently ... Pt. lives in ILF [independent living facility], pt's family lives nearby and able to assist with transportation, facility responsible for housekeeping and meal preparation ... Pt. lives in ILF, has shower chair with grab</p>			

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	<p>bars in WIS [walk in shower] and grab bars near toilet.</p> <p>D. A certified occupational therapy assistant visit dated 5/25/17 at 1 PM evidenced the patient is able to sit to stand with stand by assist. This was signed by Employee E, COTA.</p> <p>E. A physical therapy assistant (PTA) visit signed by Employee C and dated 5/25/17 at 14:10 PM evidenced the patient was able to transfer from sit to stand and from stand to sit with stand by assist. There was no physical help given. The patient completed exercises on the Nu - Step machine.</p> <p>F. A physical therapy assistant visit signed by Employee C, PTA dated 6/1/17 at 13:36 PM evidenced the patient was able to transfer with sit / stand and stand / sit with stand by assist and was able to ambulate X 300 feet with rollator walker. The patient warmed up on a Nu - step machine at this visit.</p> <p>G. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care document evidenced a blank face to face encounter on 6/8/17 with no physician notes or encounter or signature.</p>			

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	<p>H. During an interview on 6/19/17 at 10:35 AM, the director of nursing indicated that this patient was homebound and caregivers provided care to the patient. She did indicate that the assessment was not completely filled out.</p> <p>I. During an interview with patient #1 on 6/19/17 at 12:10 PM, patient #1 indicated the ability to complete all activities of daily living independently including eating, dressing, toileting, transferring, transferring, and walking. She indicated that she was not homebound and was able to go out with friends and family to shop. She was able to walk to her physical therapy / occupational therapy in the rehab. room in the independent living without difficulty. She indicated she did not have caregivers help her with activities of daily living such as toileting, dressing, grooming, or bathing.</p> <p>2. A review of Clinical record #4's record included a start of care 4/21/17 and evidenced an incomplete and inaccurate initial assessment. The SN assessment in finding #A evidenced the patient was homebound and had a difficult time leaving the home. The PT and OT evaluations showed the patient was able to leave the apartment with a</p>			

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	<p>rolling walker. This was evidenced by the following:</p> <p>A. A review of a start of care "SN - Nursing C2 / ICD 10 v. 16.3" dated 4/7/17 and signed by Employee B, RN, on 4/21/17 evidenced an initial assessment that showed the patient was homebound and had a difficult and taxing effort to leave home and requires assist of 1 - 2 people. This document evidenced the patient was alert and oriented. This is not accurate as shown in finding #B - #D below:</p> <p>B. A review of a Physical Therapy evaluation signed by Employee A, physical therapist, dated 4/11/17 with a time in of 2:18 PM and time out of 3:04 PM stated that this patient uses rollater walker outside of apartment and lives in a independent living facility. The Tinetti Assessment completed on 4/11/17 was included in this evaluation visit and evidenced the patient was able to arise without using arms.</p> <p>C. A review of an Occupational Therapy Evaluation signed by Employee D, OT, dated 4/11/17 with a time in of 1:30 PM and time out of 2:11 PM evidenced the patient was able to complete bed mobility, toilet transfer, dynamic sitting balance, and static</p>			

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	<p>standing balance with stand by assist. A tub / shower assist and dynamic standing balance was completed by the patient with minimal assist. The patient is able to self feed and toilet with modified independent function. The patient is able to complete oral hygiene, groom, upper body bathing.</p> <p>D. During a phone interview on 6/11/17 at 7:10 PM, patient #4 indicated being a patient of a physical therapy company and attending therapy in a rehab room. The patient indicated being completely independent with all personal care and not having a need for home health services. The patient was not aware of being a patient with a home health agency and did not receive rights from a home health agency. The patient indicated being discharged recently because the rehab company needed to send in a report that needed to be approved. The patient did not know who this report would be sent to or who would approve the report.</p> <p>3. A review of Clinical record #5's record with a start of care 5/31/17 evidenced an incomplete and inaccurate initial assessment. The patient lived in an independent living facility and had no knowledge of receiving home health agency care. This was evidenced by the</p>				

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	<p>following:</p> <p>A. A OASIS - C2 Start of care assessment document dated 5/31/17 and signed by Employee C, Registered Nurse, was not complete or accurate. The section titled "Type of Assistance Patient Receives" had not been completed including who provided ADL assist / bathing, dressing, toileting, bowel / bladder, eating / feeding.</p> <p>M 2012 The Types and Sources of Assistance evidenced that the patient had nonagency caregivers currently providing assistance with ADL's and that this assistance was provided 3 times a week or more. The M 1860 ambulation / locomotion section indicated the patient could only walk with the supervision or assistance of another person at all times. The GO170C mobility section evidenced the patient needed partial / moderate assistance: the helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort. This assessment also stated that the patient is able to bear weight and pivot with transfer process but unable to transfer self. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A physical therapy evaluation</p>			

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	<p>signed by Employee A, PT, and dated 6/1/17 evidenced the patient lived in an independent living facility. Patient is oriented to person, place, time. Patient is able to sit to stand, stand to sit, and toilet with stand by assist.</p> <p>C. An OT evaluation dated 6/1/17 and signed by Employee D, OT, evidenced this patient lived in Independent Living facility. The patient is able to ambulate with assistive device and completed all ADL's and transfers with Modified Independent / Independently.</p> <p>D. During a phone interview on 6/11/17 at 7:15 PM, patient #5 indicated not having any home health agency care. This patient indicated attending outpatient rehabilitation services in a rehabilitation room in the independent living facility where he / she lives. He / she did not recall receiving any written notice of patient rights from this agency. The patient indicated enjoying activities at the facility where he / she lived including dances and was able to participate in these dances.</p> <p>E. During an interview on 6/19/17 at 12 noon, the director of nursing and Employee I, RN, stated, "[He / she] has good days and bad days."</p>				

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	<p>F. A review of the Physician's Attestation of Face to Face Encounter for Patient Receiving Home Care" evidenced a blank face to face encounter on 6/15/17.</p> <p>4. A review of clinical record #9 with a start of care of 4/6/17 evidenced an incomplete and inaccurate initial assessment. The payer source is Medicare. This was evidenced by the following:</p> <p>A. A review of an OASIS - C2 Start of Care assessment completed on 4/6/17 with a signature of Employee K, RN, evidenced the patient lived in a congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section. Types and sources of assistance ADL assistance was checked that non - agency caregivers were currently providing assistance. M1810 and M 1820 evidenced the patient was able to dress self if clothes were laid or handed to patient. The mobility section numbered GG010C stated, "Safety and quality of performance - the patient needed supervision or touching assistance - helper sets up or cleans up and patient completes activity.</p>			

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	<p>B. A review of a occupational therapy evaluation dated 4/7/17 and signature of Employee D, OT, evidenced the patient was independent with bathing and dressing.</p> <p>C. During an interview on 6/14/17 at 8:15 AM, patient #9 indicated he / she was able to attend therapy sessions in the therapy room away from his / her apartment.</p> <p>D. During an interview on 6/14/17 at 1:30 PM, patient #9's physician indicated patient is alert and oriented times 3 (to time/person/place). Patient's physician indicated not being aware of patient's home status.</p> <p>5. A review of clinical record #11 with a start of care 5/24/17 evidenced an incomplete and inaccurate initial assessment. This patient lived alone and was able to complete ADLs independently. The initial assessment did not show that the patient had this level of independence. This was evidenced by the following:</p> <p>A. A review of an OASIS-C2 Start of Care assessment completed on 5/24/17 with a signature of Employee B, RN, evidenced the patient lived in a</p>				

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	<p>congregate living situation in an independent living facility. Type of assistance patient received was not completed concerning ADL or IADL type of assistance under the M1100 section.</p> <p>The M2102 Types and Sources of Assistance evidenced boxes checked that included the following: ADL assistance nonagency caregiver provide assistance, IADL assistance box checked that non-agency currently provide assistance, supervision and safety box was checked that non-agency caregiver provide assistance. These caregivers provided assistance one two times per week. The patient's mobility was shown as a 04 which meant that supervision or touching assistance was provided and a helper provides verbal cues or touching / steadying assistance as patient completes activity. M 1700 Functioning is alert and oriented and able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>B. A review of an OT evaluation completed on 5/30/17 completed by Employee D, OT, evidenced patient could complete grooming with minimal assist, dress the lower body with minimal assist and toilet with supervision.</p> <p>C. During a home visit observation on 6/13/17 at 11:15 AM, patient #11 was</p>			

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	<p>observed to answer door independently and was able to transfer per self and ambulate per self.</p> <p>D. During a home visit observation interview on 6/13/17 at 12 noon, patient #11 indicated living alone in an independent living facility and being able to perform tasks like dressing independently.</p> <p>6. The undated agency policy titled "Clinical records / Medical Record Retention" stated, "Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members ... documentation shall reflect observations and should be objective and non- judgmental."</p> <p>7. During the entrance conference on 6/8/17 at 11 AM, the director of nursing indicated the initial and comprehensive assessments were combined in a start of care assessment and not usually completed separately but could be.</p>			

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N 0541  Bldg. 00	<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 observation, record review and interview, the Registered Nurse failed to re-evaluate a patient's nursing needs in relation to a foot assessment in 1 of 2 home visits observed with a Registered Nurse (patient #7 and Employee N, RN) and failed to ensure comprehensive assessments completed upon the patient's return home from in-patient facilities were complete and accurately reflected the patient's status in 1 of 2 active records reviewed of patients who had a resumption of care and were completed within 48 hours of the patient's return home from an in - patient facility (#3).</p> <p>The findings include:</p> <p>1. Regarding an incomplete foot assessment by the RN :</p> <p>A. During a home visit observation on 6/12/17 at 2:15 PM, Employee N, Registered Nurse, was observed to complete a skilled nurse visit with patient #7. The nurse palpated the pedal pulse area of the patient's feet but did not pull</p>			N 0541	<p><b>N 541</b> 1) The agency will immediately reevaluate the patients' nursing needs with assessments each visit. This may include oasis completion. A. All RN's will receive reeducation and training on completing assessments with SOC, ROC or assessments at regularly scheduled visits and documentation of findings. Assessments will be based on patients' medical status, diagnosis, goals and outcomes anticipated. B. All RN's will receive reeducation and training on case management, coordination of care and following patients in the hospital to reduce delay in Resumption of Care. 2) The Clinical Manager will complete supervisory visits with field RN's quarterly to ensure complete appropriate assessments are completed on each visit. This will be ongoing. 3) The Administrator and Clinical Manager (DON) are responsible. 4) Date of Compliance is 08/4/17.</p>		08/04/2017

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	<p>of the patient's shoes and look at the entire feet.</p> <p>B. During an interview on 6/15/17, the director of nursing indicated the nurse did not look at the entire area of the feet.</p> <p>C. During a review of clinical record #7 and the document titled "Home Health Certification and Plan of Care" for the certification period of 5/14/17 - 7/12/17. This plan of care evidenced skilled nurse orders for 1 times a week for 9 weeks for assessment of patient.</p> <p>2. Regarding a resumption of care visit that was not within 48 hours of patient's return home from hospital</p> <p>A. Clinical record #3 included a resumption of care assessment dated 6/5/17 after a patient's return from an inpatient hospital stay. The patient had been in the hospital from 5/31/17 - 6/2/17. Employee B, Registered Nurse, completed this clinical document titled "OASIS C2 Resumption of Care on 6/5/17.</p> <p>B. A hospital document titled with the patient's name and hospital name stated, "Date of admission 5/31/17 and date of discharge 6/2/17.</p>			

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N 0547 Bldg. 00	<p>C. A review of the record evidenced a ROC (resumption of care) order dated 6/5/17. Priority Rehab Home Health is to resume home health services following the patient admission at [name of hospital] from 6/1/17 - 6/4/17. 6/5/17 is the start date for the ROC. Tramadol 50 mg twice a day was added as a new medication. The diagnosis was T 12 compression fracture. The was signed by Employee B, RN.</p> <p>3. During an interview on 6/19/17 at 2:50 PM, the director of nursing indicated the resumption was late because they were not notified of the patient's return home from the hospital.</p> <p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the agency failed to ensure the physicians' verbal, telephone, and plan of care orders were put into writing and signed and dated with the date of receipt by the</p>	N 0547	The agency will immediately ensure they have physicians' verbal, telephone and plan of care orders put into writing and signed with the date & time of receipt by the registered nurse or qualified therapist.	08/04/2017

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	<p>registered nurse or qualified therapist responsible for furnishing or supervising the ordered services for 4 of 12 records reviewed (#1, #2, #4, #6).</p> <p>The findings include:</p> <p>1. A review of clinical record #1 failed to evidence signed physician start of care orders for skilled nursing to see this patient for home health services. This was evidenced as follows:</p> <p>A. A document identified as a prescription dated 5/8/17 and signed by the physician evidenced the following statement: Physical Therapy consult and treat. DX [diagnosis] generalized deconditioning right shoulder pain." This fax had been sent to the independent living via fax on 5/11/17. There was no documentation showing that home health, occupational therapy, or skilled nursing was ordered.</p> <p>B. A review of a document titled "A physician order for start of care" with patient #1's name on it and the signature of Employee A, physical therapist. This order with for Physical Therapy evaluation and treatment and Occupational Therapy evaluation and treat. There was no inclusion of skilled nursing and the physician had not signed</p>		<p>A. Before initiating services for a home health admission the Clinical Manager or alternate will verify that a qualified order for admission to services has been obtained and documented per CMS guidelines.</p> <p>B. All direct care staff will receive re-education on obtaining and documentation of physician orders.</p> <p>C. All office staff will receive re-education on internal processing within the EMR to ensure orders are entered correctly and tracking appropriately.</p> <p>2) Clinical Manager or alternate to audit start of care for compliance content for item A on 100% of new SOC. This process will be ongoing. The Clinical Manager will audit all orders of 100% of new patient admitted after 8/04/17 for compliance x3 months and then 10% quarterly.</p> <p>3) The Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance is 08/04/17</p>	

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	<p>this order.</p> <p>C. A review of the record evidenced a start of care assessment visit titled "OASIS C2 Start of Care" dated 5/22/17 and completed by the registered nurses: Director of Nursing and Employee B, RN.</p> <p>D. During an interview on 6/19/17 at 10:25 AM, the director of nursing indicated the orders were not complete and failed to include a signed physician order for skilled nursing.</p> <p>2. A review of clinical record #2 with a start of care date of 2/16/17 evidenced a plan of care that was not completed and signed in a timely manner. There were three different plans of care all for the same certification period found in the clinical record. Each of these differed from the other plans of care for the same certification period. Two were signed by the registered nurse and physician on different dates. Medications varied on these documents. This was evidenced by the following:</p> <p>A. A review on 6/8/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a document that was signed by the</p>			

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	<p>Employee B, RN, and not signed by the physician. Employee B signed this document on 4/14/17. There was no hydrocodone on this plan of care. Orders included skilled nurse 1 times a week for 9 weeks and as needed for emergency assessment. Physical therapy 1 x 1 weeks and 3 X 6 weeks. Occupational therapy 1 -2 week X 5 weeks and 1 X 4 weeks. Home health aide services 2 times a week for 9 weeks. This plan of care was not signed by the physician when reviewed on 6/8/17.</p> <p>i. During an interview on 6/8/17 at 4 PM, Employee I, RN, indicated the plan of care had not been signed by the physician.</p> <p>B. A review on 6/9/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced an incomplete document that had been signed by the physician on 4/25/17 and the nurse, Employee B, Registered Nurse, on 4/17/17. This document was not complete. This plan of care failed to give the patient's complete address, a principal diagnosis, and nutritional requirements. The medications on this plan of care included hydrocodone / acetaminophen by mouth tablet 5 - 325 milligrams 2 tablets every 6 hours.</p>			

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	<p>C. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a Home Health Certification and Plan of care with a certification period of 4/17/17 - 6/15/17 signed by Employee B, RN, on 4/14/17 and the physician on 5/23/17. This is not a timely physician signature. This was reviewed on 6/9/17.</p> <p>i. During an interview on 6/9/17 at 9:10 AM, the director of nursing indicated the plan of care had been incomplete when it was sent to the physician and needed to be resent to the physician after it had been completed. She did not indicate how this occurred but did indicate this is why there was more than one plan of care for the same certification period.</p> <p>3. A review of clinical record #4 with a start of care date of 4/7/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p>A A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/7/17 - 6/5/17 evidenced a document that was signed by the Employee B, RN,</p>			

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	<p>and signed by the physician on 6/13/17. Employee B, RN, signed the verbal order start of care on 4/7/17.</p> <p>4. A review of clinical record #6 with a start of care date of 3/1/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/30/17 - 6/28/17 evidenced a document that was signed by the Employee B, RN, and signed by the physician on 6/18/17. Employee B, RN, signed the verbal order start of care on 4/29/17.</p> <p style="padding-left: 40px;">B. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated the plan of care was not signed by the physician in a timely manner.</p> <p>5. The undated agency policy titled "Physician Orders" stated, "Policy All medications, treatments and services must be ordered by a physician. The orders may be initiated via telephone or in writing and be countersigned by the physician in a timely manner. Orders may be facsimile. Orders signed by the physician may be in writing or signed electronically. All medications and</p>			

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N 0564 Bldg. 00	<p>treatments, that are part of the client's plan of care, must be ordered by the physician. Verbal orders may be taken by the licensed personnel designated by the agency in accordance with applicable state and federal law and organizational policy. Orders will be accepted only from physicians who have a current license in the state of operation."</p> <p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on home visit observation, record review and interview, the agency failed to ensure the physical therapist completed a complete pain assessment for 1 of 1 home visit observation (patient #3) of a physical therapist (Employee A) and failed to ensure the therapist (#A, # D) completed a complete pain assessment for 2 of 12 records reviewed of patients with therapy services (#3 and #4).</p> <p>The findings include:  Regarding a home visit observation with</p>	N 0564	<p>1) The appropriate therapist shall assist the physician, podiatrist, chiropractor, dentist or optometrist in evaluating level of patient function by completing a complete assessment with each home visit.</p> <p>A. All therapists will receive education and training on patient medical plan of care with patient's medical doctor and other interdisciplinary team members and completing an evaluation of level of clinical condition and function at each visit. Should pain be an identified problem, therapist will complete a pain</p>	08/18/2017

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	<p>patient #3 and Employee A, physical therapist</p> <p>1. At a home visit observation on 6/13/17 at 9:05 AM with patient #3 and Employee A, physical therapist, patient #3 was observed to ambulate from the bathroom to a chair in the living room. Patient #3 was observed to complain of severe pain and lack of appetite and food intake and constipation with lack of bowel movement for 4 days. Patient #3 indicated taking pills at 8 AM including the pain medication, Tramadol. The patient indicated the pain was at a level of a "11" on a 10 point scale with no pain relief from the tramadol. Employee A asked the patient about the pain level. Employee A did not ask the patient to describe the pain. The PT took the patient's vital signs and continued with the therapy exercises including marching in place in a seated position. At 9:32 AM, Employee A was observed to leave a voice mail on the physician's phone. Employee A asked about the patient's pain level three times through the visit and the patient answered the pain was at a level of "11" each time. These questions were asked at the beginning of the visit, the middle of the visit, and at the end of the visit. The patient answered that the pain was so severe that he / she wished to end his / her life. The patient</p>		<p>assessment each visit including documentation and management of the pain as well as coordination of care with the patients' medical doctor.</p> <p>B. All therapists will receive reeducation and training on patient pain education and identifying measurable treatment goals to ensure objective measurement of progress towards goals and / or therapy effectiveness.</p> <p>C. All therapists to be reeducated on notification to physician for any patient changes in condition.</p> <p>2) All therapy notes to be audited weekly for compliance of A for 1 month with 100% of current census. Chart audits for item B &amp; C to be complete weekly for 3 months on 100% of new admissions after 8/4/17 then 10% quarterly.</p> <p>3) Administrator and Clinical Manager (DON) are responsible.</p> <p>4) Date of Compliance 08/18/17.</p>		

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	<p>asked at the end of the visit, "What am I going to do about this pain?" The physical therapist said to take an ice pack and use it off and on about 20 minutes at a time for pain relief. The PT, Employee A stated, "Keep a good attitude and stay positive."</p> <p>Regarding incomplete pain assessments for patient #3</p> <p>2. A review of an OT (occupational therapy) evaluation visit document dated 5/30/17 signed by Employee D, OT evidenced the patient had pain in bilateral hands and right knee. This pain was not described and no pain level was completed.</p> <p>3. A review of a PT (physical therapy) evaluation visit document dated 6/6/17 signed by Employee A, Physical Therapist evidenced the patient had complained of severe pain at a level of "10" (with "0" being no pain and "10" being the most severe pain. This evaluation failed to evidence a complete pain assessment. There was no description of the pain with this assessment. This document evidenced that the factor contributing to functional impairment was weakness and back pain. The treatment goal was for the patient to report that back pain does not limit [his /</p>			

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	<p>her] ability to walk from apartment to facility dining room.</p> <p>4. A review of an OT (occupational therapy) Re-evaluation Visit document dated 6/6/17 signed by Employee D, OT evidenced the patient had complained of severe pain at a level of 10. There was no description of the pain with this assessment. The evaluation assessment summary stated, "Due to increased back pain, patient reports not leaving room for last few days for meals / going out. Pt is requiring significantly increased assistance with all self care and functional mobility tasks due to severe back pain. Pt. recently received orders from physician to wear back brace while up. Pt. requires maximum assist to don supportive back brace. Due to physical / cognitive deficits, pt's [informal caregiver] is unable to safely and accurately assist with back brace. Pt will benefit from continued OT focusing on increasing BUE [bilateral upper extremity] strength, activity tolerance, improving self - regulation of pain from arthritis symptoms and increasing functional transfers in order to maximum safety and independence with daily routine and functional mobility tasks."</p> <p>5. A review of a PT evaluation visit documented dated 6/13/17 signed by</p>			

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	<p>Employee A evidenced the patient complained of severe pain at a level of "11" on a 10 point scale. There was no description of the pain with this assessment.</p> <p>Regarding incomplete pain assessment for patient #4</p> <p>6. A review of a physical therapy evaluation date of service 6/5/17 for a re-evaluation discharge visit completed by Employee A, PT, evidenced that the patient had a pain level of a "3" at this visit. The pain is located in the "tailbone." The pain quality was not described and details about the pain were not described such as what makes the pain worse.</p> <p>During an interview on 6/19/17 at 11:35 AM, the director of nursing indicated this assessment had not been completed.</p> <p>6. The undated agency policy titled "Pain Assessment / Management" stated, "All clients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as treatment of efficacy of treatment. The agency will work with the client, family and physician, as well as other members of</p>			

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	<p>the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will be reviewed and modified if the client does not have pain relief. Poorly managed pain delays healing and recover time, alters the body's immune system and increases stress, anxiety and depression. Clients will be informed that they have the right to have pain evaluated and effectively treated. Pain will be treated as a vital sign and agency will strive to ensure that pain is measured and treated .... Pain assessment is an integral part of the initial comprehensive assessment and the client's right to expect appropriate assessment and management is explained and honored. If the client has pain that interferes with pain or movement on a daily basis or is determined to be intractable, pain management will be specified intervention on the plan of care ... Pain is assessed on every nurse / therapist home visit and documented on a pain or symptom flow sheet. Documentation will include the effectiveness of all pain interventions or modalities. The documentation will include what interventions were used and describe response / effectiveness of care. 4. Referrals to pain specialist and utilization of best practices will be documented if utilized. 5. The nurse / therapist will use</p>			

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	<p>a standardized agency accepted pain assessment tool that evaluates the locations, duration, severity [rating scale], alleviating factors, exacerbating factors, current treatment [medication and non-medication] and response to treatment. 6. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral or alternative therapy. If the established plan is ineffective and the pain management needs can not be met within the agency pain parameters, a referral will be made to an alternate provider. 7. Assessment of presence of pain and treatment / response will be incorporated into all agency assessment / reassessment tools."</p> <p>7. During an interview on 6/19/17 at 3:10 PM, the director of nursing stated, "We can only do what we can do."</p> <p>8. During an interview on 6/19/17 at 5:30 PM, the pending administrator indicated that the plan is to be there with a patient's pain. A patient's pain level is subjective and physical therapy is the plan for pain management.</p> <p>9. The undated agency policy titled "Therapy Services" stated, "Measurable treatment goals be described in the plan of care and the patient's clinical record</p>			

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N 0608 Bldg. 00	would demonstrate the method used to assess a patient's function would include objective measurement and successive comparison of measurements, thus enabling objective measurement or progress towards goals and / or therapy effectiveness."  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 home visit observation, record	N 0608	N 608	08/18/2017

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	<p>review and interview, the agency failed to ensure clinical records were maintained in accordance with professional standards and were complete and accurate for 8 of 12 clinical records reviewed (#1, #2, #3, #4, #5, #6, #8, #10).</p> <p>The findings include:</p> <p>1. A review of clinical record #1 failed to evidence a complete and accurate clinical record. The record had a Start of Care Assessment signed by two different nurses. This was evidenced as follows:</p> <p style="padding-left: 40px;">A. A review of Clinical record #1 evidenced two OASIS - C2 (Outcome and Information Assessment Set) Start of Care Assessment that were alike except having two different signatures from two different nurses. There were two of these documents dated 5/22/17 and completed at the start of care. One was signed by the director of nursing and the other signed by Employee B, Registered Nurse and both of these were in the clinical record. This review occurred on 6/19/17.</p> <p style="padding-left: 40px;">B. During an interview on 6/19/17 at 10:45 AM, the director of nursing indicated signing the other nurse's document when she made spelling and grammatical errors. She indicated that this is a common practice at this agency</p>		<p>1. During the change of ownership &amp; change in documentation systems, BHA's systems were insufficient to adequately meet the Condition of Participation 484.48 Medical Records. BHA's clinical record documentation process has been redeveloped as follows:</p> <p style="padding-left: 40px;">A. Only one qualified professional will complete and sign and date the OASIS. If modifications are required to the OASIS, the reviewer will consult with the staff person who completes the OASIS who will then decide about any changes to be made. All changes to the OASIS will be documented as to what changes were made, who made the changes, and signed and dated by the professional completing the OASIS. This will be incorporated in the Medical Record. The OASIS Guidance Manual is a resource for the completion of the OASIS and a copy is in the office.</p> <p style="padding-left: 40px;">B. The POC will be developed based on the patient's needs and in collaboration with the physician. The POC will include all the required data accurately documented</p>	

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	<p>when review of a clinical document occurs. She indicated using yellow sticky notes that would disappear after the review had occurred. Notations were not made that showed what changes had occurred or who had made these changes.</p> <p>2. A review of clinical record #2 with a start of care date of 2/16/17 evidenced a plan of care that was not completed and signed in a timely manner. There were three different plans of care all for the same certification period found in the clinical record. Each of these differed from the other plans of care for the same certification period. Two were signed by the registered nurse and physician on different dates. Medications varied on these documents. This was evidenced by the following:</p> <p>A. A review on 6/8/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a document that was signed by the Employee B, RN, and not signed by the physician. Employee B signed this document on 4/14/17. There was no hydrocodone on this plan of care. Orders included skilled nurse 1 times a week for 9 weeks and as needed for emergency assessment. Physical therapy 1 x 1 weeks and 3 X 6 weeks. Occupational</p>		<p>including a complete and accurate medication list, frequency and duration of involved services, and signature and date of the Registered Nurse or Therapist responsible for the development of the POC. The POC will indicate the patient's individualized care plan specific to their assessed needs.</p> <p>C. The POC will be signed and dated by the physician in a timely manner, within 30 days, of the SOC, and documentation will evidence the return of the signed POC in a timely manner and tracking of the order and all attempts to have the POC returned signed in a timely manner.</p> <p>D. The Verbal SOC order will be documented and reflected on the POC with the RN or Therapists signature and date.</p> <p>E. This agency will complete an Initial Assessment, which may include a Comprehensive Assessment, in a timely manner, within 48 hours of the referral date, acute care/skilled facility discharge, or on the physician ordered SOC date. As stated in</p>	

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	<p>therapy 1 -2 week X 5 weeks and 1 X 4 weeks. Home health aide services 2 times a week for 9 weeks. This plan of care was not signed by the physician when reviewed on 6/8/17.</p> <p>i. During an interview on 6/8/17 at 4 PM, Employee I, RN, indicated the plan of care had not been signed by the physician.</p> <p>B. A review on 6/9/17 of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced an incomplete document that had been signed by the physician on 4/25/17 and the nurse, Employee B, Registered Nurse, on 4/17/17. This document was not complete. This plan of care failed to give the patient's complete address, a principal diagnosis, and nutritional requirements. The medications on this plan of care included hydrocodone / acetaminophen by mouth tablet 5 - 325 milligrams 2 tablets every 6 hours.</p> <p>C. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/17/17 - 6/15/17 evidenced a Home Health Certification and Plan of care with a certification period of 4/17/17 - 6/15/17 signed by Employee B, RN, on 4/14/17</p>		<p>correction D above the Verbal SOC order will be documented and reflected on the POC &amp; in the patient record with the RN or Therapists signature and date. The assessment will evidence the patient's special needs. The POC will be developed in collaboration with the physician based on the patient's individualized assessed needs. In addition, the Initial Assessment &amp; Comprehensive Assessment documentation will be completed timely. All clinical staff (Including Clinical Manager) will be re-educated and trained on these corrective measures.</p> <p>F. The agency will complete a referral form upon receipt of the referral information. All information will be reviewed for completeness and identifying information prior to accepting the referral insuring that the referral is intended for home health not outpatient therapy. The agency referral form will be included in the medical record. All clinical staff (including Clinical Manager) as well as office staff that support the intake role will be educated and trained on these</p>		

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	<p>and the physician on 5/23/17. This is not a timely physician signature. This was reviewed on 6/9/17.</p> <p>i. During an interview on 6/9/17 at 9:10 AM, the director of nursing indicated the plan of care had been incomplete when it was sent to the physician and needed to be resent to the physician after it had been completed. She did not indicate how this occurred but did indicate this is why there was more than one plan of care for the same certification period.</p> <p>3. A review of a document titled "A SN [Skilled Nursing] C2 / ICD10 v 16.3 1. Start of Care - further visits planned on 03- 06- 2017 for patient #3 evidenced the patient had an initial assessment / comprehensive assessment completed in a timely manner. This document was dated 3/6/17 but not signed by Employee L, RN, until 3/16/17.</p> <p>A. During an interview on 6/15/17 at 3:30 PM, the director of nursing indicated that this assessment had not been completed in a timely manner.</p> <p>4. A review of a clinical record #3 document titled "Referral Order" dated 3/1/17 included a physician referral order with an outpatient therapy company's</p>		<p>corrective measures.</p> <p>G. Any needed changes to a verbal order from its original form, will be documented in the medical record and the physician will be notified of the need to modify the order. The order will be sent to the physician for signature and date. The agency tracking process will apply. All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures to verbal orders.</p> <p>H. Any modifications/errors in documentation will be corrected according to the agency policy "Documentation of Changes to the Medical Record." All clinical staff (including the Clinical Manager) to be reeducated on the process to make changes / corrective measures in documentation.</p> <p>I. The agency aide supervisory note will be accurately completed, dated and signed by the RN or Qualified Therapist and includes all the required documentation of the aide follows patient's plan of care, communicates openly with the</p>				

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	<p>name, address, and fax number, There was no referral made to this agency which is titled "Back Home Again Home Health dba Priority Rehab" and located at 291 N State Road 2 in Valparaiso, IN.</p> <p>A. During an interview on 6/9/17 at 2:30 PM, Employee J, physical therapist and owner and owner and PTA stated, "Communication with our staffing company comes to us."</p> <p>5. A review of clinical record #4 evidenced a document titled "Physician Order for Start of care" evidenced a verbal order for start of care that failed to identify the home health agency. This order included the name of an outpatient therapy company and its phone number and its fax number. This order signed by the physician and dated 4/6/17 stated, "Agency to have Registered Nurse or Licensed Therapist perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN Instruction on disease management / medication management, PT unsteady gait and muscle weakness, OT safety of environment, ADLS The Registered Nurse / Licensed Therapist will perform a full system assessment inclusive of vital signs and O2 saturation levels, a review / reconciliation of the</p>		<p>patient, family, caregivers, respects the patients' rights, is competent to perform assigned tasks, complies with infections control measures, and appropriately reports any changes in the patient's condition. Documentation is specified to the patient's needs and response to services. The Clinical Manager will in-service RN, PT, OT staff on supervision of the aide and associated required documentation.</p> <p>J. An up-to-date master schedule and patient calendar will be maintained for each patient decreasing the risk of missed visits. A missed visit form will document the event of the missed visit, date, discipline, reason for missed visit, and how patient's needs were met. The physician will be notified of all missed visits and the master schedule and patient schedule will indicate missed visits.</p> <p>K. The agency will maintain the correct and current physician having oversight of the home health care admission in the medical record of patient services and care. The current and accurate physician will be notified in a timely manner of</p>		

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	<p>client's medication regimen, a safety and fall risk assessment, nutrition, skin, depression and pain screenings. The comprehensive assessment will also include a home environment safety assessment and assessment of need for adaptive devices.</p> <p>A. During an interview on 6/19/17 at 11:45 AM, the director of nursing indicated that verbal order form had been changed.</p> <p>6. A review of clinical record #5 with a start of care on 5/31/17 evidenced documentation concerns. This review occurred on 6/19/17. This was evidenced as follows:</p> <p>A. A review of the plan of care titled "Home Health Certification and Plan of Care" for the certification period of 5/31/17 - 7/29/17 evidenced the signature of the director of nursing dated 5/31/17. A second document titled "Home Health Certification and Plan of Care" for the certification period evidenced the signature of Employee B, RN, with a date of 5/31/17. The physician signed this plan of care on 6/13/17.</p> <p>B. During an interview on 6/13/17 at 3:30 PM, the director of nursing indicated this was a clerical error. She</p>		<p>all incidents that affect and/or require modification to the POC. The agency will maintain the current and correct physician with contact information and all required information (i.e. NPI, PECOS, License, and confirmed by patient and physician). The Clinical Manager and all clinical staff to be reeducated and trained on these corrective measures.</p> <p>L. The agency will in-service all professional staff on the following agency policies:</p> <p>Physician Orders Medical Supervision Clinical Documentation Clinical Records/Medical Retention Documentation of Changes to the Medical Record</p> <p>The agency staff will sign a statement stating they understand these policies and agree to compliance with these policies. The signed statements will be included in the employees personnel file. Any contract staff will be included in the in-servicing process and will also sign the statement of understanding and compliance. The contract</p>		

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	<p>stated, "I sent it to the physician. I also sent to [employee B] for corrections. This was a clerical error."</p> <p>7. A review of clinical record #6 with a start of care date of 3/1/17 evidenced a plan of care not signed in a timely manner. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A review of a plan of care titled "Home Health Certification and Plan of Care" for the certification period of 4/30/17 - 6/28/17 evidenced a document that was signed by the Employee B, RN, and signed by the physician on 6/18/17. Employee B, RN, signed the verbal order start of care on 4/29/17.</p> <p style="padding-left: 40px;">B. During an interview on 6/19/17 at 3:10 PM, the director of nursing indicated the plan of care was not signed by the physician in a timely manner.</p> <p>8. A review of clinical record #8 with a start of care date of 6/2/17 evidenced a plan of care with a certification period of 6/8/17 - 8/6/17 and the plan of care not individualized for this patient. This was evidenced as follows:</p> <p style="padding-left: 40px;">A. A review of a physician order for start of care evidenced a physician order dated 5/31/17 and a start of care 6/1/17</p>		<p>staff signed statement will be included in the contract file. Should errors continue staff will be counseled.</p> <p>2. Initially 100% of all new SOC assessments after 08/04/17 will be audited for 3 months for evidence that the OASIS is completed accurately and that all changes are noted in the medical recorded indicating who made the changes, what changes were made, signed and dated by the professional completing the OASIS; that all orders, including POC, are completed accurately; that the Initial Assessment / Comprehensive Assessment is completed within the regular time frames; that the referral form is completed accurately and that the referral is appropriate for the agency; that all changes to the medical record are compliant with the agency policy; that all changes to the medical record are compliant with agency policy.</p> <p>Ongoing 10% of all clinical records will be audited quarterly for evidence that the deficiencies do not reoccur including accurate completion of the Initial Assessment /</p>		

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	<p>for the skilled nurse to admit and evaluate and treat for home health, PT to evaluate and treat, and OT evaluate and treat."</p> <p>B. A review of a physician verbal order with titled "Orders" with a signature of Employee B dated 6/2/17 stated, "POSOC [physician order start of care] per patient request d/t [due to] still moving in facility."</p> <p>C. A review of the record evidenced a "Home Health Certification and Plan of care" plan of care document with a date of the RN, Employee B, on 6/8/17 and the physician on 6/15/17. This plan of care evidenced a certification period of 6/8/17 - 8/6/17 and start of care date of 6/2/17. The date of 6/2/17 was inaccurate. The start of care date was 6/8/17. The RN, Employee A, visited the patient on 6/8/17 for the initial assessment / comprehensive assessment.</p> <p>D. During an interview on 6/16/17 at 3:20 PM, the director of nursing indicated the patient delayed the start of care due to moving in to his / her apartment during that time and choosing to delay the start of care. She indicated this was a clerical error.</p> <p>9. A review of the clinical record #10</p>		<p>Comprehensive Assessment; that the referral process is completed accurately; that Oasis completion is accurate; that changes to the medical record are compliant; that aide supervisory visits are accurate and reflect individualized patient needs; that missed visits are recorded accurately; that the physician on record is accurate and they are notified.</p> <p>3. The administrator is responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p> <p>4. Correction date: 08/18/17</p>				

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	<p>with a start of care of 4/21/17 evidenced aide supervision notes that were identical from one visit on 6/2/17 to another on 6/8/17 and that the attending physician had been changed to another attending physician and physician orders were still sent to the first attending physician. This was evidenced as follows:</p> <p>Regarding two identical notes:</p> <p>A. A review of an Aide Supervisory Visit dated 6/2/17 and signed by Employee B, Registered Nurse, stated, "Supervision date 6/2/17, Supervisor name [Employee B, RN], clinician name [Employee O, Home Health Aide (HHA) ], clinician present at time of visit checked "No", Notifies client / caregiver of schedule: Excellent, Reports for duty as assigned [Excellent], Cooperative with client's and others: Excellent, Courteous toward client and others: excellent, Documents appropriately: Excellent, Timely notification to supervisor of client's needs or changes in condition Excellent, no changes made to care plan, patient satisfied with current plan, Comments: No HHA Visits in past 2 weeks. One week daughter in town and was able to assist patient, this week pt refused d / t weakness R / T pneumonia. Pt states feeling improved and requires HHA to come Tuesday, SN [skilled</p>			

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	<p>nurse] will confirm with HHA."</p> <p>B. A review of an Aide Supervisory Visit dated 6/8/17 and signed by Employee B, Registered Nurse, stated, "Supervision date 6/8/17, Supervisor name [Employee B, RN], clinician name [Employee O, Home Health Aide ], clinician present at time of visit checked "No", Notifies client / caregiver of schedule: Excellent, Reports for duty as assigned [Excellent], Cooperative with client's and others: Excellent, Courteous toward client and others: excellent, Documents appropriately: Excellent, Timely notification to supervisor of client's needs or changes in condition Excellent, no changes made to care plan, patient satisfied with current plan, Comments: No HHA Visits in past 2 weeks. One week daughter in town and was able to assist patient, this week pt refused d / t weakness R / T pneumonia. Pt states feeling improved and requires HHA to come Tuesday, SN [skilled nurse] will confirm with HHA."</p> <p>C. During an interview on 6/19/17 at 2:20 PM, the director of nursing indicated the notes were the same except the dates.</p> <p>D. During an interview on 6/19/17 at 2:20 PM, Employee M, physical therapy</p>			

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	<p>assistant and owner, stated, "Not a rule that nothing can be changed".</p> <p>Regarding the lack of updating the new attending physician and sent to the physician no longer involved in patient 's care</p> <p>E. A review of the "Home Health Certification and Plan of Care" with a certification date of 4/21/17 - 6/19/17 evidenced a box titled "Physician's Name and Address with the attending physician's name and address. This physician's name and address were crossed off and error written over this physician's name and address. A second physician's name and NPI (national provider identifier) number were entered below in the box.</p> <p>F. A review of the missed visit form (OT Visit) dated 5/25/17 and signed by Employee D, OT, evidenced this form was sent to the first physician who was no longer the attending physician. This documented stated, "No answer to locked door."</p> <p>G. A review of the missed visit form (COTA Visit) dated 6/2/17 and signed by Employee E, COTA, evidenced this form was sent to the first physician who was no longer the attending physician. This</p>			

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	<p>documented stated, "Pt out of town."</p> <p>H. A review of the missed visit form (Physical Therapy Re - Evaluation with Supervisory Visit) dated 6/9/17 and signed by Employee A, Physical Therapist, evidenced this form was sent to the first physician who was no longer the attending physician. This documented stated, "PT. Reports still feeling ill and requesting to reschedule PT visit for next week."</p> <p>I. During an interview on 6/19/17 at 2:30 PM, Employee M and Employee P, receptionist, indicated that the software program was not updating yet and in the next episode this will fix itself.</p> <p>10. The undated agency policy titled "Physician Orders" stated, "All medications, treatments and services provided to clients must be ordered by a physician. The orders must be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. Orders may be received via facsimile. Orders signed by physician may in writing or signed electronically ... verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy ... 1. When the nurse or therapist receives a</p>			

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	<p>verbal order from the physician, he / she shall write the order as given and then read the order back to the physician verifying that the person receives the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, the specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature. Verbal orders received during an initial assessment / evaluation may be documented on the 485 and sent to the physician for signature."</p> <p>11. The undated agency policy titled "Medical Supervision stated, "Physicians will be informed at the time their clients are admitted to the agency, of each parties' responsibilities in managing client's care ... the client's primary physician shall be responsible of approving signed orders and for establishing and reviewing the client's plan of care throughout the time the client is receiving services."</p> <p>12. The undated agency policy titled "Clinical Documentation" stated, "Agency will document each direct contact with the client's. This</p>			

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	<p>documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the client's care. Purpose: To ensure that there is an accurate record of the services provided, client response, and ongoing need for care. To document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement. Special instructions: 1. All skilled services provided by Nursing, Therapy, or Social Services will be documented in the clinical record. 2. A separate note shall be completed for each visit / shift and signed and dated by the appropriate professional. Actual time and length of the client's visit will be included in each note ... Services not provided and the reason for missed visits will be documented and reported to the physician."</p> <p>13. The undated agency policy titled "Clinical records / Medical Retention" stated, "A clinical record will be maintained for every client receiving home health services. All client's information shall be regarded as confidential and available only to authorized users. Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health</p>			

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	and emotional status, treatments, and services rendered by the Registered Professional Nurses and other health care team members. The agency is to use an electronic medical record retention system for client charts. A paper chart may be utilized, and retained according to state guidelines, until the EMR is fully integrated ... Purpose: To maintain an accurate record of the services provided by the agency for each client's. To provide a mechanism by which client's care information is documented, maintained, protected and utilized, and transferred as appropriate. To safeguard the integrity of information maintained in clinical and billing records. Special instructions: Clinical record. 1. A confidential clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every client receiving home health services ... 4. Documentation shall reflect observations and should be objective and non-judgmental ... 5. Documentation shall establish that effective interchange, reporting, and coordination of care does occur. 6. All documentation must be legible and if written on paper be written in ink [preferably black ] or typewritten ... 9. Since the clinical record is a legal document, no form may be removed or destroyed once it is filed within the chart			

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	<p>... 10. In the event that an employee wishes to correct data, it shall be done as an amendment without change to the original entry. It shall be identified as an additional document appended to the original clinical record."</p> <p>14. The agency document titled "Kinnser Online Help Task and Episode Comments" dated 2017 stated, "Tasks and episode comments also known as yellow and purple sticky notes let you append the information on a task or episode level. This is really useful for maintaining advisory information related to scheduled task / visit as well as information that applies to the entire episode. The following provides an overview of the available sticky note options available within Kinnser as well as their functions and general use. Yellow stick notes Yellow sticky notes or task comments are located within the Details section of task and are generally used to document extra details or information regarding a particular visit. These task specific comments can be added or edited at any time, regardless of the task's status, and do not appear within the Print View of the visit note. During the review process, a QUA person is able to make comments for correction within the yellow comment box prior to returning in to eh Clinician. Comments</p>						

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	<p>made will appear as a yellow sticky note icon within the assigned clinicians' hot box, the QA Manager box, and the patient's episode manager page and can be reviewed by hovering your mouse cursor over the icon. Unlike tasks, however, once a yellow sticky note has been deleted, it cannot be restored."</p> <p>15. The undated agency policy titled "Documentation of Changes to the Medical Record" stated, "Medical records are legal documents that support the delivery of client services. Any changes or revisions of information documented in the client record must follow accepted legal requirements. Purpose: Documentation provides evidence that the agency provided the client services. The format of the record shows interventions provided according to the plan of care and is consistent with the requirements of the agency standard, Medicare regulations and payer requirements. Accuracy and correct documentation of the OASIS assessments are critical components of reimbursement as well as regulation. Special instructions: 1. All entries into the record must be legible. The use of white out is not allowed. Entries may not be erased or scratched out. 2. When it is necessary to correct an entry in the clinical record: a. draw a single line</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157562	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2017
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NAME OF PROVIDER OR SUPPLIER  BACK HOME AGAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 291 N STATE RD 2 VALPARAISO, IN 46383
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	through the statement. b. Write the date the correction was made and sign with first and last initial. C. Write the correct information. 3. If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to. 4. Changes to OASIS documentation a. The OASIS assessment tool is a legal part of the record. It should not be treated as a worksheet. B. The clinician who completes the assessment form is responsible of making changes [corrections, revisions, additions] to the document. c. The clinical supervisor or designee may enter changes based on the review of the assessment. These changes must be documented in the record identifying the reason for the changes and the communication of those changes to the authoring clinician. These changes must also be initialed and dated as noted above. 5. Electronic health records ... a. Records sourced from electronic systems containing amendments, corrections, or delayed entries must distinctly identify any amendment, correction or delayed entry and provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the records."			

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