

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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NAME OF PROVIDER OR SUPPLIER HOME NURSING SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 528 W WASHINGTON BLVD FORT WAYNE, IN 46802
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G 000 Bldg. 00	<p>This was a home health federal recertification survey. This was an extended survey.</p> <p>Survey Dates: May 6-12, 2015. Partial Extended Dates: May 6, 7, 8, and 11, 2015. Extended Dates: May 12, 2015.</p> <p>Facility Number: IN005372</p> <p>Medicaid Number: 100265370A</p> <p>Census Service Type: Skilled: 49 Home Health Aide Only: 137 Personal Care Only: 95 Total: 281</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6 HV w/o RR: 0 Total: 12</p> <p>Home Nursing Services is precluded from providing its own Home Health Aide training and competency evaluation program for a period of 2 years beginning</p>	G 000	Home Nursing Services takes these findings very seriously. Home Nursing Services held a governing body meeting. It is our hope that you find this Corrective Action Plan as our credible allegation of compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G 110 Bldg. 00	<p>May 12, 2015, through May 12, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, & Medical Supervision and 42 CFR 484.48: Clinical Records.</p> <p>QA: JE 05/18/15</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> <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 observation, and interview, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 1 of 6 home visit observations. (#1)</p>	G 110	A list has been developed that addresses all documents required to be in the home in order to be in full compliance with state and federal regulations. This includes a copy of the current Advanced Directive Law dated July 2013. All staff will be inserviced by June	06/17/2015

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G 121 Bldg. 00	<p>Findings include</p> <p>1. Clinical record #1, start of care 7/28/11, failed to evidence the patient had been provided an updated Advanced Directives document revised July 2013.</p> <p>On 5/8/15 at 9 AM, a home visit was conducted to patient #1. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>2. During interview on 5/6/15 at 12:20 PM, employee I, the administrator, indicated the agency has the current packet available.</p> <p>3. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 4 of 6 home visit</p>	G 121	<p>17, 2015. on which documents must be present in the client's home file. RNCMs will complete a 100% audit of all client home files by June 17, 2015, to ensure that all items are present in the home files. Ongoing compliance will be ensured by the RNCMs reviewing all clients files at every supervisory and/or skilled nurse visit. Clinical Director is responsible for ongoing compliance with this regulation.</p> <p>By 5/15/15, all employees will be given copies of our Handwashing/Hand Hygiene and Standard Precautions for All Health Care Workers. Home</p>	06/17/2015

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	<p>observations. (# 1, 2, 3, and 5)</p> <p>Findings include</p> <p>1. During observation on 5/8/15 at 9 AM with patient #1, employee Q, a home health aide (HHA), was observed providing a shower.</p> <p style="padding-left: 40px;">A. After washing the patient's back, employee Q removed gloves and donned clean gloves. Employee Q failed to wash hands or use hand sanitizer after removing gloves and prior to donning clean gloves.</p> <p style="padding-left: 40px;">B. Employee Q took patient's dirty laundry to laundry room, sorted and placed in washing machine. Employee Q failed to remove gloves and wash hands or use hand sanitizer after handling soiled laundry and prior to exiting laundry room.</p> <p>2. During observation on 5/8/15 at 10:45 AM, employee R, a HHA, was observed providing a shower for patient #2.</p> <p style="padding-left: 40px;">A. Employee R donned gloves and assisted patient to bathroom. Employee R removed dirty bowel movement (BM) soiled brief and took it to the trash can, moved the toiled riser back over the toiled, and placed urinal on toilet riser</p>		<p>Nursing Services follows the standards set by the CDC and WHO. By 5/15/15, all employees that failed to perform adequate hand hygiene during the surveyor's home visits will be competency tested on hand hygiene. By 5/22/15, Employee B will be inserviced on Pressure Ulcer Dressing Change and Wound Care. Employee B will also be competency tested on Wound Care and Dressing Changes and appropriate hand washing procedures. By 6/17/15, 100% of employees will be competency tested on hand hygiene. By 6/17/15, 100% of LPNs/RNs will be competency tested on wound care/dressing changes. We will require annual competency tests on all staff to ensure that adequate hand hygiene is demonstrated. We will require annual competency tests on all nurses to ensure that proper wound care and dressing change policies are followed. At orientation, all staff will complete a competency test on hand hygiene. Clinical Director will ensure ongoing compliance with this standard.</p>		

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	<p>rail. Employee R failed to remove gloves after disposing of the dirty brief, and proceeded to rinse the same gloves in the bathroom sink. Employee Q failed to change gloves. Employee Q proceeded to wash the patient's feet, back, and buttocks and then rinsed the soap from gloves prior to placing bath mat on floor. Employee Q proceeded to dry the patient, apply deodorant and lotion, and dress patient.</p> <p>B. Employee Q removed gloves and rinsed hands at kitchen sink. Employee failed to wash hands with soap.</p> <p>C. Employee Q donned clean gloves and cleaned BM from wheel chair seat cushion with a wet rag. Employee Q failed to remove gloves prior to obtaining clean paper towel from roll.</p> <p>3. During observation on 5/8/15 at 12:00 PM, employee B, a licensed practical nurse (LPN), was observed providing wound care to patient # 3.</p> <p>A. Employee B donned clean gloves, gathered soap and water, washed wound #1 on the patient's left ankle, removed old dressing, and applied Mepilex. Employee B failed to remove gloves and perform hand washing or use hand sanitizer, and failed to don clean gloves</p>			

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	<p>prior to applying Mepilex on wound.</p> <p>B. Employee B washed hands and donned clean gloves, and proceeded to next wound to patient's left inner knee. Employee B removed the old dressing/packing, cleansed the wound, reached into the Mepilex package with same gloves, and applied the Mepilex to the wound. Employee B failed to change gloves and wash hands or use hand sanitizer prior to obtaining and applying the Mepilex.</p> <p>C. Employee B removed gloves and washed hands for approximately 5 seconds, then donned clean gloves. Bed pad contained BM on pad and old dressing on left buttocks and left hip wounds. Employee B removed the old dressing from the right buttock dressing, and reached into the 4 x 4 dressing package. Employee B failed to change gloves and perform hand washing or use hand sanitizer prior to reaching into 4 x 4 dressing package and after removing old dressing. Employee B proceeded to dip the new 4 x 4 dressing into the Normal Saline (NS) and cleansed the wound, and then applied the Gentamycin/Dakins' kerlix to the wound.</p> <p>D. Employee B removed dirty gloves and washed hands for approximately 5</p>			

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	<p>seconds, then donned clean gloves.</p> <p>E. Employee B removed the old dressing from the left inner buttock wound, reached into the 4 x 4 package, placed 4 x 4 in NS, cleaned the wound, rinsed it, and proceeded to apply the Gentamycin/Dakins' kerlix to the wound. Employee B failed to change gloves and perform hand washing or use hand sanitizer prior to reaching into 4 x 4 dressing package and after removing old dressing.</p> <p>F. Employee B removed the old dressing from the left outer buttock/hip wound, removed gloves, and washed hands for approximately 5 seconds, then donned clean gloves. Employee B cleansed the wound with soap and water, then patient had a BM and it smeared onto the clean dressings. Employee B wiped the BM and removed it, then removed gloves and washed hands for approximately 5 seconds prior to donning clean gloves. Employee B applied new tape and dressing, removed gloves, and donned clean gloves. Employee B failed to wash hands for longer than 5 seconds, and failed to wash hands or use hand sanitizer prior to donning clean gloves.</p> <p>During interview on 5/8/15 at 12:35 PM, patient # 3 indicated the nurse</p>			

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	<p>usually just changes gloves and does not wash hands in between, but the agency provides good care.</p> <p>4. During home visit # 5 on 5/8/15 at 2:45 PM, employee C, a LPN, was observed providing and in and out catheter for patient #5. Employee E, a HHA, was also present to assist with moving the patient, and was also observed providing care.</p> <p>A. Employee C washed hands for approximately 5 seconds, prior to donning 2 pair of clean gloves. Employee C failed to wash hands longer than 5 seconds.</p> <p>B. Employee C proceeded with the in/out catheter procedure. Employee C cleaned the patient with her right hand and then held up her right hand and the HHA removed the first glove, to expose the second glove. Employee C then proceeded to insert the catheter with her right hand. Employee C failed to remove the dirty gloves, wash hands or use hand sanitizer and don clean gloves, prior to inserting the catheter.</p> <p>C. The HHA was observed preparing the patient to get up into the wheel chair. Employee E donned 3 pair of gloves. The LPN assisted with rolling the patient,</p>			

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	<p>then employee E washed the patient's buttocks and applied a new brief, and applied lotion to the patient. Employee E then removed 1 pair of gloves and proceeded to wash the patient's perineal area and applied lotion to the patient's abdominal folds, and removed the second pair of gloves. Employee E then adjusted the patient's brief and then removed the third pair of gloves, rinsed her hands, and proceeded to dress the patient. Employee E failed to remove old gloves and wash hands or use hand sanitizer between tasks; failed to don clean gloves between tasks; failed to wash the patient's perineal area prior to the back area, and failed to wash hands longer than 5 seconds.</p> <p>D. The clinical record (#5) evidenced a Physician Order dated 3/9/15 notifying the physician that the patient had been discharged from the hospital with a diagnosis of Urinary Tract Infection (UTI).</p> <p>E. The agency's hospitalization report dated 1/8-5/2/15 evidenced patient #5 was admitted to the hospital from 1/8-1/13/15 with diagnosis listed as "abdominal cyst, UTI," and 3/4-3/9/15 with diagnosis of "UTI," and from 3/27-3/31/15 with diagnosis of "UTI, pain."</p>			

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	<p>5. During interview on 5/11/15 at 9:30 AM, employee J, the Nursing Supervisor, indicated employees should wash hands or use hand sanitizer upon arrival to the home, and after contact with patients.</p> <p>6. During interview on 5/11/15 at 9:30 AM, employee I, the administrator, indicated employees should wash hands or use hand sanitizer in between glove changes.</p> <p>7. During interview on 5/11/15 at 9:32 AM, employee I indicated staff should wash hands for at least 20 seconds.</p> <p>8. During interview on 5/11/15 at 9:35 AM, employee I indicated staff should change gloves after removing old dressings and prior to applying new dressings with wound care.</p> <p>9. During interview on 5/11/15 at 9:44 AM, employee J indicated Medicaid does not supply or pay for sterile gloves, so the in and out catheter procedure is a clean procedure.</p> <p>10. The agency's undated policy titled "Standard Precautions for all Health Care Workers," # D-245, states, "Gloves should be changed after each client contact. When gloves are removed, thorough hand washing is required.</p>			

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	<p>Gloves do not take the place of hand washing."</p> <p>11. The agency's undated policy titled "Handwashing/Hand Hygiene," # D-330, states, "3. Indications for hand washing and hand antisepsis: a. Before performing invasive procedures. b. Before caring for clients at high-risk for infection. c. When there is prolonged or intense contact with the client (bathing the client). d. Between tasks on the same client. e. Before touching a wound. f. After removing gloves. g. After touching objects that are potentially contaminated. ... n. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Alternatively, wash hands with antimicrobial soap and water in all clinical situations. o. Decontaminate hands before having direct contact with clients, before donning sterile gloves to insert urinary catheters, ... p. Decontaminate hands after contact with client's intact skin, after contact with body fluids, excretions, non intact skin and wound dressings. ... r. Decontaminate hands after removing gloves. ... Hand Hygiene Technique ... 2. when washing hands with soap and water, ... rub hands together vigorously for at least twenty (20) seconds, covering</p>			

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G 141	<p>all surfaces of hand and fingers."</p> <p>12. The agency's undated policy titled "Pressure Ulcer Dressing Change," # G-160, states, "Equipment/Supplies ... Gloves. (sterile and non sterile). ... Procedure ... 4. Put on gloves and remove old dressing and discard. ... 6. Apply new pair of gloves. ... 10. Cleanse the wound bed."</p> <p>13. The agency's undated policy titled "Intermittent Catheterization," # D-110, states, "Equipment/Supplies ... One pair of disposable gloves."</p> <p>14. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p>				

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Bldg. 00	<p>PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on employee file review, policy review, and interview, the agency failed to ensure each employee had a criminal history check within 3 days of providing patient care for 1 of 8 personnel records reviewed. (C)</p> <p>Findings include</p> <ol style="list-style-type: none"> Employee file C, a licensed practical nurse, date of hire 3/13/08 and date of first patient contact 3/18/08, failed to evidence a criminal history check was completed until 4/3/08. During interview on 5/12/15 at 9:10 AM, employee I, the administrator, indicated the criminal history check was missed and there was not an earlier one. The agency's undated policy titled "Criminal Background Checks," # D-190, states, "Employees will not be able to start working with clients until the background check clearance has been received by Home Nursing Services." The agency's undated policy titled 	G 141	<p>Home Nursing Services's current personnel file review process involves a thorough review by the Administrator, so that no employee has patient contact prior to a limited state criminal background check. The Administrator will review all personnel files prior to first client contact to ensure that a limited state criminal background check has been completed. Administrator will be responsible for ongoing compliance.</p>	06/17/2015
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G 156 Bldg. 00	<p>"Personnel Records," # D-180, states, "1. Personnel Records: a. The personnel record for an employee may include, but not be limited to: b. Pre-employment Information: ... Criminal history and background checks as required by law."</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure all visits were provided as ordered by the physician and failed to ensure any missed visits were communicated with the physician for 1 of 12 clinical records reviewed (see G 158); failed to ensure the plan of care contained accurate and complete information for 2 of 12 clinical records reviewed (see G 159); failed to ensure the 60 day summaries were updated to reflect changes in patient condition for 3 of 12 records reviewed (see G 163); and failed to ensure the physicians were notified of patient discharge from the agency for 2 of 4 discharge records reviewed (see G 164).</p>	G 156	<p>The agency will ensure that all visits are provided as ordered by the physician. The agency will ensure that missed visits are communicated to the physician. The agency will ensure that the Plan of Care contains accurate and complete clinical information. The agency will ensure that sixty day summaries are updated every certification period. The agency will update the physician by communicating all changes in patient condition and will ensure that the physicians are notified of all patient discharges from the agency. Clinical Director and Administrator will be responsible for ensuring ongoing compliance with this Condition of Participation.</p>	06/17/2015

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G 158 Bldg. 00	<p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with 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 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review, policy review, and interview, the agency failed to ensure all visits were provided as ordered by the physician and failed to ensure any missed visits were communicated to the physician for 1 of 12 clinical records reviewed. (# 5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 1/30/06, contained a plan of care dated 3/23-5/21/15 with orders for skilled nurse (SN) 3 visits per day times 9 weeks and home health aide 3 hours each morning,</p>	G 158	<p>We will ensure all visits are provided as ordered by the physician and any missed visits will be communicated to the physician. By 5/22/15, client record #5 will be reviewed and the physician will be notified of the missed visits during the certification period 3/23/15-5/21/15 due to weekly attendance on Thursdays at Turnstone Center for Children and Adults with Disabilities. By 5/22/15, client record #5 will be amended to list Turnstone services on the client's Plan of Care (485) for coordination of care purposes. The Clinical Director will ensure ongoing</p>	06/17/2015

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	<p>noon, and evening 7 days a week for 9 weeks.</p> <p>The record failed to evidence the SN visits were completed as ordered for Noon visits on 3/26, 4/2, 4/9, and 4/23/15. The record failed to evidence any missed visit notifications to the physician.</p> <p>2. During interview on 5/11/14 at 3:20 PM, employee J, the nursing supervisor, indicated there are not Noon visits on those days because the patient sometimes goes to Turnstone. Employee J indicated this is the patient's choice to miss those times, so they do not need to notify the physician.</p> <p>The record failed to evidence documentation the patient had gone to Turnstone.</p> <p>3. The agency's undated and un-numbered policy titled "Clinical Documentation," states,"6. Services not provided and the reason for the missed visits will be documented and reported to the physician."</p> <p>4. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p>		compliance with this regulation.	

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G 159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care (POC) contained accurate and complete information for 2 of 12 clinical records reviewed. (# 5, and 7)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #5, start of care date (SOC) 1/30/06, contained a POC dated 3/23-5/21/15. The POC evidenced the SOC date as 10/3/06. The clinical record evidenced the client signed the services agreement form on 1/30/06. 2. Clinical record #7, SOC date 4/13/15, contained a POC dated 4/13-6/11/15. The POC failed to evidence a code status. <p>During interview on 5/11/15 at 11:55</p>	G 159	By 5/22/15, the 485s for Client #5 and #7 will be amended to include code status. By 6/17/15, the code status for all clients will be reflected on either the current 485 or a physician's order. By 6/17/15, we will verify the SOC date for Client Record #5. Clinical records will be audited at certification time points through Soneto, our clinical records software program. Clinical Director will ensure ongoing compliance with this regulation.	06/17/2015

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G 163 Bldg. 00	<p>AM, employee I, the administrator, indicated the code status is usually in the last section of the POC, but it is also on the admitting record face sheet, and a copy is also in the patient binders in their homes. Employee I indicated if the POC does not have a code status listed, the patients are considered a full code unless they or the physician specify otherwise.</p> <p>3. The agency's undated policy titled "Physician Orders," # C-635, states "All medications, treatments, that are part of the client's plan of care, must be ordered by a physician."</p> <p>4. The agency's undated policy titled "Comprehensive Client Assessment," # C-145, states "3. In addition to general health status/system management, Home Nursing Services comprehensive assessment tool ... will include: ... m. Emergent care data."</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as</p>				

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	<p>often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, and interview, the agency failed to ensure the 60 day summaries reflected changes in patient condition for 3 of 12 records reviewed. (# 2, 3, and 6)</p> <p>Findings include</p> <ol style="list-style-type: none"> Clinical record # 2, start of care (SOC) date 3/4/13, contained a plan of care (POC) dated 2/22-4/22/15 with a 60 day summary that stated, "Client is having a decline in [their] abilities." This summary failed to identify the decline of abilities. <p>The POC for the certification period 4/23-6/21/15 60 day summary stated, "Client is having a decline in [their] abilities." This summary failed to identify the decline of abilities.</p> <ol style="list-style-type: none"> Clinical record # 3, SOC date 	G 163	<p>Clinical records will be audited to ensure that each sixty day summary is updated at each certification period to reflect the client's current status. As we transition to Electronic Health Records (EHRs), a process we began on 4/1/15, clients' 485s will require typing current summaries at each certification period.</p> <p>Soneto will not copy the summary from one certification period to the next. By 6/17/15, Clinical records #2, 3, and 6 will be updated to reflect the current condition of the client. These updated statements will be sent to the physician by 6/17/15. Sixty day summaries will be included in the audit at certification time points through Soneto, our clinical records software program. Clinical Director will ensure ongoing compliance with this regulation.</p>	06/17/2015

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	<p>10/27/14, contained a POC dated 2/24-4/24/15 with a 60 day summary that stated, "Currently the client has 5 pressure ulcers that require SN [skilled nurse] dressing changes daily."</p> <p>A. The POC dated 4/25-6/23/15 60 day summary stated, "Client has multiple pressure ulcers." This summary failed to identify how many more pressure ulcers the client developed or the status of the pressure ulcers.</p> <p>B. The clinical record evidenced the 5 pressure ulcers had improved.</p> <p>3. Clinical record # 6, SOC date 10/2/13, contained a POC dated 2/14-4/14/15 with a 60 day summary that stated, "Client is considered a fall risk ... and [client] has fallen recently." The clinical record failed to evidence the patient had fallen recently.</p> <p>The POC dated 4/15-6/13/15 60 day summary stated, "Client is considered a fall risk ... and has fallen recently." The clinical record failed to evidence the patient had fallen recently.</p> <p>4. During interview on 5/11/15 at 2:00 PM, employee J, the nursing supervisor, indicated she did not see any recent falls documented for patient #6, so she is not</p>			

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G 164 Bldg. 00	<p>sure why the 60 day summary still says recent fall.</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review, policy review, and interview, the agency failed to ensure the physician was notified of patient discharge from the agency for 2 of 4 discharge records reviewed. (# 10, and 12)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care (SOC) date 4/24/07, evidenced the patient was discharge on 3/24/15. The record failed to evidence physician notification of discharge, and failed to contain a discharge summary.</p> <p>2. Clinical record # 12, SOC date 6/27/14, evidenced the patient was discharged on 4/15/15. The record failed to evidence physician notification of</p>	G 164	<p>By 6/17/15, a discharge summary for Clinical Records #10 and #12 will be written and sent to the physician. By 6/17/15, all RN Case Managers were inserviced on required documentation at the time of client discharge. By 6/17/15, all discharged client records will be audited to ensure the physician was notified of discharge and sent a discharge summary. By 6/17/15, the Quality Assurance Coordinator will audit 100% of discharged clinical records to ensure physician was notified of discharged and sent a discharge summary. By 6/17/15, the Clinical Director will ensure ongoing compliance with this regulation.</p>	06/17/2015

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	<p>discharge and failed to contain a discharge summary.</p> <p>3. During interview on 5/6/15 at 2:45 PM, employee I, the administrator, indicated there is not a discharge summary in the chart nor in the computer for both patients. Employee I indicated discharge summaries are to be sent to the physician when they are completed.</p> <p>4. The agency's undated policy titled "Client Discharge Process," # C-500, states, "5. The Registered Nurse shall review the clinical record to assure accuracy and completion. A Discharge Summary shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family. ... d. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician."</p> <p>5. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge</p>			

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G 224 Bldg. 00	<p>Summary. y. Discharge Instructions. 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, ... from admission to discharge."</p> <p>6. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) delegated tasks appropriately and within the scope of practice to the Home Health Aides (HHA) for 1 of 11 records reviewed of patients receiving HHA services. (#5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 1/30/06, contained a plan of care dated 3/23-5/21/15 with orders for SN (skilled</p>	G 224	<p>On 5/12/15, Employees C and E were notified by telephone to explain that Home Health Aides are not permitted to perform tasks outside their scope. Client #5 was also notified on 5/12/15 by telephone (and by email) that Home Health Aides are not permitted to perform tasks outside their scope. On 5/12/15, all office staff were notified via email that Home Health Aides are not permitted to perform tasks outside their scope. By 5/15/15, all staff will be given a copy of our</p>	06/17/2015

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	<p>nurse) 3 visits each day for 9 weeks to assess vital signs and all body systems, ... Change colostomy wafer every 3-4 days and as needed for leakage, straight cath with 16 french three times a day, 7 days a week using clean technique, Administer eye drops 2 times daily and any other medications as needed. And, HHA 3 hours daily in AM 7 times a week, 2 hours daily midday 7 times a week, 3 hours daily PM 7 times a week for 9 weeks to assist with bathing, grooming, dressing, safe transfers with Hoyer lift, meal prep, feed client, remind client to take meds, change depends and toileting, empty colostomy bag as needed, do ROM [range of motion] of extremities, reposition client in wheel chair or bed as needed, equipment care, and any other personal care needs and ADLs (activities of daily living), as requested.</p> <p>A. The record evidenced three HHA Service Plans reviewed on 3/19/15, one for AM visits, one for Noon visits, and one for HS (hour of sleep) visits. Each service plan evidenced the RN assigned the HHA to the following tasks: "Change colostomy bag as needed. HHA can change wafer if checked off by RN [Registered Nurse]. Call RN after task done."</p>		nurse delegation policy, prohibiting home health aides from administering medications or any other duty beyond their scope. By 6/17/15, the Home Health Aide Assignment Sheets for Client #5 will be updated to clearly indicate the specific, varied tasks for each shift of care provided. RNCMs will assess compliance during each present supervisory visit to ensure that the home health aide is operating within the scope of their certification. Clinical Director will ensure ongoing compliance with this regulation.	

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	<p>B. The three HHA Service Plans contained all the same tasks for all three HHA visits including Tub/Shower, Bath-Partial/Complete, Assist with Dressing, Hair Care, Skin Care, check Pressure Areas, Shave/Groom/Deodorant, Nail Hygiene, Oral Care, Elimination Assist, Ostomy care, Assist with Medications (remind only), ambulation assist, mobility assist, range of motion passive and active, positioning, regular diet, meal preparation, assist with feeding, encourage fluids, grocery shopping, laundry, light house keeping, and equipment care.</p> <p>2. During interview on 5/11/15 at 1:50 PM, employee J, the nursing supervisor, indicated any HHA seeing patient #5 is checked off to perform the wafer and colostomy bag change. But the colostomy care means emptying, and there are enough nurses going to see the patient that the HHAs haven't had to change the bag or the wafer, and if they did it would be documented in the comments section of their documentation.</p> <p>3. During interview on 5/11/15 at 2:05 PM, employee J indicated the agency consulted someone who told the agency the HHAs could change the colostomy bag and wafer as long as they were competencied on it by an RN.</p>				

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	<p>4. During employee file review on 5/12/15, employee file E, a HHA, evidenced an In-Service and training Report dated 6/25/14 with the topic "Changing colostomy wafer," and the summary section evidenced the check-off included "Observe skin around stoma, ... Call SN of changes in skin and or stoma."</p> <p>A. Employee file C also evidenced the agency competency evaluated the HHA for Aerosol Nebulizer.</p> <p>The "Aerosol Nebulizers Competency Evaluation" sheet dated 5/16 (no year specified) as the competency evaluation date, but the RN (employee T) dated it 4/15/15. This competency sheet performance criteria stated, "1. Checks physician orders and determines type of nebulizer/inhaler client is using ... 4. Prepares nebulizer by filling with prescribed amount of medication ... 6. Inserts mouthpiece or attaches adapter to begin administration."</p> <p>5. During interview on 5/11/15 at 9:50 AM, employee J, the nursing supervisor, indicated patient # 5 needs an inhaler and stated, "Our source said we can assign to the HHA as long as they are competencied by the RN."</p>			

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	<p>6. The agency's undated policy titled "Ostomy Care," # E-190, states, "Applies to: Registered Nurses, Licensed Practical/Vocational Nurses, Therapists. ... Procedure: ... 7. Assess skin condition."</p> <p>7. The agency's undated policy titled "Home Health Aide Assignment Sheet," # C-751, states, "2. The Assignment Sheet shall be developed in plain, non-technical lay terms and identify the duties to be performed, such as, but not limited to: ... d. Assistance with medications that are ordinarily self-administered."</p> <p>8. The agency's undated policy titled "Home Health Aide Services," # C-220, states, "The duties of a home health aide include the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in administering medications that are ordinarily self-administered. ... Purpose: To abide by state/federal guidelines and offer guidelines to Home Nursing services staff, physicians, and community for the appropriate utilization of Home Health Aide services. Special Instructions- 1. Home Health Aide services may include: ... j. Assisting with medications, and other delegated nursing</p>			

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G 235 Bldg. 00	<p>tasks as directed by the Registered Nurse and in accordance with state law and Home Nursing Services policy. ... 4. Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific State/Federal and Home Nursing Services policies."</p> <p>9. The agency's undated job description titled "Home Health Aide," # D-470, states, "4. Reminds the client in administration of medications that are ordinarily self-administered under the direction and supervision of a Registered Nurse."</p> <p>10. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the accuracy of clinical records, including performance of tasks by home health aides, and failed to ensure each discharge record contained a discharge summary and discharge assessment (see G236) and failed to ensure a discharge summary was created</p>	G 235	The agency will ensure the accuracy of clinical records, the performance of tasks by the home health aides, and ensure each discharge record contains a discharge summary and a	06/17/2015

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G 236 Bldg. 00	<p>and in the record (see G303).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.</p> <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the accuracy of clinical records, including performance of tasks by home health aides (HHA), for 1 of 11 records reviewed of patients receiving HHA services (# 5) and failed to ensure each discharge record contained a discharge summary and discharge assessment for 2 of 4 discharge records reviewed. (# 10, and 12)</p> <p>Findings include</p>	G 236	<p>discharge assessment where appropriate.</p> <p>By 6/17/15, the Home Health Aide Assignment Sheets for Client #5 will be updated to clearly indicate the specific, varied tasks for each shift of care provided. By 6/17/15, all agency home health aides will be inserviced on proper documentation of tasks performed. By 6/17/15, all RN Case Managers will be inserviced on required documentation at the time of client discharge. By 6/17/15, all discharged client records will be audited for to ensure the physician was notified of discharge and sent a discharge summary. By 6/17/15, the Quality Assurance Coordinator will audit</p>	06/17/2015

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	<p>1. Clinical record #5, start of care (SOC) date 1/30/06, contained a plan of care (POC) dated 3/23-5/21/15 with orders for SN (skilled nurse) 3 visits each day for 9 weeks, HHA 3 hours daily in AM 7 times a week, 2 hours daily midday 7 times a week, and 3 hours daily PM 7 times a week for 9 weeks to assist with bathing, grooming, dressing, safe transfers with Hoyer lift, meal prep, feed client, remind client to take meds, change depends and toileting, empty colostomy bag as needed, do ROM [range of motion] of extremities, and reposition client in wheel chair or bed as needed, equipment care, and any other personal care needs and ADLs (activities of daily living) as requested.</p> <p>A. The three HHA Service Plans, reviewed on 3/19/15, contained all the same tasks for all three HHA visits including Tub/Shower, Bath-Partial/Complete, Assist with Dressing, Hair Care, Skin Care, check Pressure Areas, Shave/Groom/Deodorant, Nail Hygiene, Oral Care, Elimination Assist, Ostomy care, Assist with Medications (remind only), ambulation assist, mobility assist, range of motion passive and active, positioning, regular diet, meal preparation, assist with feeding, encourage fluids, grocery shopping, laundry, light house keeping,</p>		100% of discharged clinical records to ensure physician was notified of discharged and sent a discharge summary. By 6/17/15, 100% of home health aide documentation will be audited by First Impressions Coordinator to ensure compliance with the assignment sheet. The Clinical Director and Administrator will ensure ongoing compliance with this regulation.	

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	<p>and equipment care.</p> <p>B. The HHA Weekly Visit Record for the dates 3/23-5/3/15, for all HHA shifts, failed to evidence which task was performed by the HHAs. The sections titled "Tub/Shower, Bath-Partial/Complete, Hair Care- Brush, Shampoo/Other, Skin Care/Foot Care (Hygiene), Shave/Groom/Deodorant, Nail Hygiene- Clean/File/Report, Oral Care- Brush/Swab/Dentures, Ambulation Assist- WC/Walker/Cane, Limit/Encourage Fluids, and Light Housekeeping- Bedroom/Bathroom/Kitchen-Change Bed Linen" failed to evidence which tasks were performed by the HHAs.</p> <p>C. During interview on 5/11/15 at 1:55 PM, employee J, the nursing supervisor, indicated patient # 5 does not receive tub bathing.</p> <p>2. Clinical record # 10, start of care (SOC) date 4/24/07, evidenced the patient was discharged on 3/24/15. The record failed to contain a discharge summary.</p> <p>3. Clinical record # 12, SOC date 6/27/14, evidenced the patient was discharged on 4/15/15. The record failed to contain a discharge summary.</p>			

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	<p>4. During interview on 5/6/15 at 2:45 PM, employee I, the administrator, indicated there is not a discharge summary in the chart, nor in the computer for patients 10 and 12.</p> <p>5. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. y. Discharge Instructions. 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, ... from admission to discharge."</p> <p>6. The agency's undated policy titled "Home Health Aide: Documentation," no number, states, "Purpose- To provide documentation of the care performed by the Home Health Aide on each visit. ... Special Instructions- ... 3. The designated Registered Nurse or designated person is responsible for reviewing the Home Health Aide's charting before it is placed in the chart."</p> <p>7. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In</p>			

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G 303 Bldg. 00	<p>addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. ... 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, psychosocial status, safety measures to protect the client from injury, and medical care provided, as applicable, from admission to discharge. ... 8. ... when a client is discharged from care, the clinical record shall be completed (including required summary, documentation, and signature) within an appropriate time frame (identified by the Home Nursing Services).</p> <p>8. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. Based on clinical record review, policy review, and interview, the agency failed</p>	G 303	By 6/17/15, all RN Case Managers will be inserviced on required documentation at the	06/17/2015

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	<p>to ensure a discharge summary was created and in the record for 2 of 4 discharge records reviewed. (# 10, and 12)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record # 10, start of care (SOC) date 4/24/07, evidenced the patient was discharged on 3/24/15. The record failed to contain a discharge summary. 2. Clinical record # 12, SOC date 6/27/14, evidenced the patient was discharged on 4/15/15. The record failed to contain a discharge summary. 3. During interview on 5/6/15 at 2:45 PM, employee I, the administrator, indicated there was not a discharge summary in the chart nor in the computer for both patients. 4. The agency's undated policy titled "Client Discharge Process," # C-500, states, "5. The Registered Nurse shall review the clinical record to assure accuracy and completion. A Discharge Summary shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and 		<p>time of client discharge. By 6/17/15, all discharged client records will be audited to ensure the physician was notified of discharge and sent a discharge summary. By 6/17/15, the Quality Assurance Coordinator will audit 100% of discharged clinical records to ensure physician was notified of discharged and sent a discharge summary. Clinical Director will ensure ongoing compliance with this regulation.</p>	

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G 339 Bldg. 00	<p>family. ... d. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician."</p> <p>5. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. y. Discharge Instructions. 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, ... from admission to discharge."</p> <p>6. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p>			

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	<p>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure the collected Recertification Outcome Assessment Information Set (OASIS) data accurately reflected the patients' status for 1 of 12 clinical records reviewed. (# 5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 1/30/06, contained an OASIS Follow-Up assessment dated 3/19/15. This OASIS Follow-Up assessment (Recertification) failed to evidence a Hoyer lift was identified under the section Durable Medical Equipment and Supplies (DME).</p> <p>A. During home visit observation on 5/8/15 at 2:45 PM, a Hoyer lift was observed in the patient's home.</p> <p>B. The OASIS section titled "Goals" evidenced the nurse selected, "The patient's skin and mucous membranes will remain intact for this certification period." The OASIS assessment failed to evidence the patient had any problems with skin or mucous membranes, and documentation states, "Skin Turgor: Good, Skin Color: Pink, Skin: Dry, Warm, Skin: Ostomy, Nails: Normal."</p>	G 339	<p>The agency will ensure congruence between the re-certification assessment and the Plan of Care. The agency will ensure that goals on the 485 will be both client-specific and based on the assessment. By 6/17/15, all RNCMs will be inserviced on the importance of making all client goals very specific and assessment based.</p> <p>Documentation will be audited by the Quality Assurance Coordinator at certification time points to ensure that goals are client specific and congruent with the assessment. Clinical Director will ensure ongoing compliance with this regulation.</p>	06/17/2015

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	<p>C. The OASIS follow-up assessment failed to evidence the nurse selected any goals related to urinary catheterization and/or to be free from Urinary Tract Infections.</p> <p>1.) The clinical record (#5) evidenced a Physician Order dated 3/9/15 notifying the physician that the patient had been discharged from the hospital with a diagnosis of Urinary Tract Infection (UTI).</p> <p>2.) The agency's hospitalization report dated 1/8-5/2/15 evidenced patient #5 was admitted to the hospital from 1/8-1/13/15 with diagnosis listed as "abdominal cyst, UTI," and 3/4-3/9/15 with diagnosis of "UTI," and from 3/27-3/31/15 with diagnosis of "UTI, pain."</p> <p>2. During interview on 5/11/15 at 1:30 PM, employee J, the nursing supervisor, indicated the case managers talk with patients about goals, but she doesn't think they are putting on as many goals as they could be.</p> <p>3. During interview on 5/11/15 at 1:45 PM, employee J indicated the plan of care and the OASIS assessment should be reflective of each other.</p>			

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N 000 Bldg. 00	<p>4. The agency's undated policy titled "Comprehensive Client Assessment," # C-145, states, "The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. ... Purpose- To determine the appropriate care, treatment and services to meet client initial needs and his/her changing needs. To collect data about the client's history, ... and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individuals response to care. ... 3. In addition to general health status/system assessment, Home Nursing Services comprehensive assessment tool with OASIS will include: ... 1. Equipment management."</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>This was a home health state license survey.</p> <p>Survey Dates: May 6-12, 2015.</p> <p>Facility Number: IN005372</p>	N 000	Home Nursing Services takes these findings very seriously. Home Nursing Services held a governing body meeting. It is our hope that you find this Corrective Action Plan as our credible allegation of compliance.	

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N 458 Bldg. 00	<p>Medicaid Number: 100265370A</p> <p>Census Service Type: Skilled: 49 Home Health Aide Only: 137 Personal Care Only: 95 Total: 281</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6 HV w/o RR: 0 Total: 12</p> <p>QA: JE 05/18/15</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration.</p>			

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	<p>(5) Annual performance evaluations. Based on employee file review, policy review, and interview, the agency failed to ensure each employee had a criminal history check within 3 days of providing patient care for 1 of 8 personnel records reviewed. (C)</p> <p>Findings include</p> <ol style="list-style-type: none"> Employee file C, a licensed practical nurse, date of hire 3/13/08 and date of first patient contact 3/18/08, failed to evidence a criminal history check was completed until 4/3/08. During interview on 5/12/15 at 9:10 AM, employee I, the administrator, indicated the criminal history check was missed and there was not an earlier one. The agency's undated policy titled "Criminal Background Checks," # D-190, states, "Employees will not be able to start working with clients until the background check clearance has been received by Home Nursing Services." The agency's undated policy titled "Personnel Records," # D-180, states, "1. Personnel Records: a. The personnel record for an employee may include, but not be limited to: b. Pre-employment Information: ... Criminal history and 	N 458	Agency's current personnel file review process involves a thorough review by the Administrator, so that no employee has patient contact prior to a limited state criminal background check. The Administrator will review all personnel files prior to first client contact to ensure that a limited state criminal background check has been completed. Administrator will be responsible for ongoing compliance.	06/17/2015

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N 470 Bldg. 00	<p>background checks as required by law."</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 4 of 6 home visit observations. (# 1, 2, 3, and 5)</p> <p>Findings include</p> <p>1. During observation on 5/8/15 at 9 AM with patient #1, employee Q, a home health aide (HHA), was observed providing a shower.</p> <p>A. After washing the patient's back, employee Q removed gloves and donned clean gloves. Employee Q failed to wash hands or use hand sanitizer after removing gloves and prior to donning clean gloves.</p>	N 470	By 5/15/15, all employees will be given copies of our Handwashing/Hand Hygiene and Standard Precautions for All Health Care Workers. The agency follows the standards set by the CDC and WHO. By 5/15/15, all employees that failed to perform adequate hand hygiene during the surveyor's home visits will be competency tested on hand hygiene. By 5/22/15, Employee B will be inserviced on Pressure Ulcer Dressing Change and Wound Care. Employee B will also be competency tested on Wound Care and Dressing Changes and appropriate hand washing procedures. By 6/17/15, 100% of employees will be competency tested on hand hygiene. By 6/17/15, 100% of LPNs/RNs will be competency tested on wound	06/17/2015

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	<p>B. Employee Q took patient's dirty laundry to laundry room, sorted and placed in washing machine. Employee Q failed to remove gloves and wash hands or use hand sanitizer after handling soiled laundry and prior to exiting laundry room.</p> <p>2. During observation on 5/8/15 at 10:45 AM, employee R, a HHA, was observed providing a shower for patient #2.</p> <p>A. Employee R donned gloves and assisted patient to bathroom. Employee R removed dirty bowel movement (BM) soiled brief and took it to the trash can, moved the toiled riser back over the toiled, and placed urinal on toilet riser rail. Employee R failed to remove gloves after disposing of the dirty brief, and proceeded to rinse the same gloves in the bathroom sink. Employee Q failed to change gloves. Employee Q proceeded to wash the patient's feet, back, and buttocks and then rinsed the soap from gloves prior to placing bath mat on floor. Employee Q proceeded to dry the patient, apply deodorant and lotion, and dress patient.</p> <p>B. Employee Q removed gloves and rinsed hands at kitchen sink. Employee failed to wash hands with soap.</p>		<p>care/dressing changes. We will require annual competency tests on all staff to ensure that adequate hand hygiene is demonstrated. We will require annual competency tests on all nurses to ensure that proper wound care and dressing change policies are followed. At orientation, all staff will complete a competency test on hand hygiene. Clinical Director will ensure ongoing compliance with this standard.</p>	

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	<p>C. Employee Q donned clean gloves and cleaned BM from wheel chair seat cushion with a wet rag. Employee Q failed to remove gloves prior to obtaining clean paper towel from roll.</p> <p>3. During observation on 5/8/15 at 12:00 PM, employee B, a licensed practical nurse (LPN), was observed providing wound care to patient # 3.</p> <p>A. Employee B donned clean gloves, gathered soap and water, washed wound #1 on the patient's left ankle, removed old dressing, and applied Mepilex. Employee B failed to remove gloves and perform hand washing or use hand sanitizer, and failed to don clean gloves prior to applying Mepilex on wound.</p> <p>B. Employee B washed hands and donned clean gloves, and proceeded to next wound to patient's left inner knee. Employee B removed the old dressing/packing, cleansed the wound, reached into the Mepilex package with same gloves, and applied the Mepilex to the wound. Employee B failed to change gloves and wash hands or use hand sanitizer prior to obtaining and applying the Mepilex.</p> <p>C. Employee B removed gloves and</p>			

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	<p>washed hands for approximately 5 seconds, then donned clean gloves. Bed pad contained BM on pad and old dressing on left buttocks and left hip wounds. Employee B removed the old dressing from the right buttock dressing, and reached into the 4 x 4 dressing package. Employee B failed to change gloves and perform hand washing or use hand sanitizer prior to reaching into 4 x 4 dressing package and after removing old dressing. Employee B proceeded to dip the new 4 x 4 dressing into the Normal Saline (NS) and cleansed the wound, and then applied the Gentamycin/Dakins' kerlix to the wound.</p> <p>D. Employee B removed dirty gloves and washed hands for approximately 5 seconds, then donned clean gloves.</p> <p>E. Employee B removed the old dressing from the left inner buttock wound, reached into the 4 x 4 package, placed 4 x 4 in NS, cleaned the wound, rinsed it, and proceeded to apply the Gentamycin/Dakins' kerlix to the wound. Employee B failed to change gloves and perform hand washing or use hand sanitizer prior to reaching into 4 x 4 dressing package and after removing old dressing.</p> <p>F. Employee B removed the old</p>			

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	<p>dressings from the left outer buttock/hip wound, removed gloves, and washed hands for approximately 5 seconds, then donned clean gloves. Employee B cleansed the wound with soap and water, then patient had a BM and it smeared onto the clean dressings. Employee B wiped the BM and removed it, then removed gloves and washed hands for approximately 5 seconds prior to donning clean gloves. Employee B applied new tape and dressing, removed gloves, and donned clean gloves. Employee B failed to wash hands for longer than 5 seconds, and failed to wash hands or use hand sanitizer prior to donning clean gloves.</p> <p>During interview on 5/8/15 at 12:35 PM, patient # 3 indicated the nurse usually just changes gloves and does not wash hands in between, but the agency provides good care.</p> <p>4. During home visit # 5 on 5/8/15 at 2:45 PM, employee C, a LPN, was observed providing and in and out catheter for patient #5. Employee E, a HHA, was also present to assist with moving the patient, and was also observed providing care.</p> <p>A. Employee C washed hands for approximately 5 seconds, prior to donning 2 pair of clean gloves.</p>			

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	<p>Employee C failed to wash hands longer than 5 seconds.</p> <p>B. Employee C proceeded with the in/out catheter procedure. Employee C cleaned the patient with her right hand and then held up her right hand and the HHA removed the first glove, to expose the second glove. Employee C then proceeded to insert the catheter with her right hand. Employee C failed to remove the dirty gloves, wash hands or use hand sanitizer and don clean gloves, prior to inserting the catheter.</p> <p>C. The HHA was observed preparing the patient to get up into the wheel chair. Employee E donned 3 pair of gloves. The LPN assisted with rolling the patient, then employee E washed the patient's buttocks and applied a new brief, and applied lotion to the patient. Employee E then removed 1 pair of gloves and proceeded to wash the patient's perineal area and applied lotion to the patient's abdominal folds, and removed the second pair of gloves. Employee E then adjusted the patient's brief and then removed the third pair of gloves, rinsed her hands, and proceeded to dress the patient. Employee E failed to remove old gloves and wash hands or use hand sanitizer between tasks; failed to don clean gloves between tasks; failed to wash the patient's perineal</p>			

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	<p>area prior to the back area, and failed to wash hands longer than 5 seconds.</p> <p>D. The clinical record (#5) evidenced a Physician Order dated 3/9/15 notifying the physician that the patient had been discharged from the hospital with a diagnosis of Urinary Tract Infection (UTI).</p> <p>E. The agency's hospitalization report dated 1/8-5/2/15 evidenced patient #5 was admitted to the hospital from 1/8-1/13/15 with diagnosis listed as "abdominal cyst, UTI," and 3/4-3/9/15 with diagnosis of "UTI," and from 3/27-3/31/15 with diagnosis of "UTI, pain."</p> <p>5. During interview on 5/11/15 at 9:30 AM, employee J, the Nursing Supervisor, indicated employees should wash hands or use hand sanitizer upon arrival to the home, and after contact with patients.</p> <p>6. During interview on 5/11/15 at 9:30 AM, employee I, the administrator, indicated employees should wash hands or use hand sanitizer in between glove changes.</p> <p>7. During interview on 5/11/15 at 9:32 AM, employee I indicated staff should wash hands for at least 20 seconds.</p>			

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	<p>8. During interview on 5/11/15 at 9:35 AM, employee I indicated staff should change gloves after removing old dressings and prior to applying new dressings with wound care.</p> <p>9. During interview on 5/11/15 at 9:44 AM, employee J indicated Medicaid does not supply or pay for sterile gloves, so the in and out catheter procedure is a clean procedure.</p> <p>10. The agency's undated policy titled "Standard Precautions for all Health Care Workers," # D-245, states, "Gloves should be changed after each client contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing."</p> <p>11. The agency's undated policy titled "Handwashing/Hand Hygiene," # D-330, states, "3. Indications for hand washing and hand antisepsis: a. Before performing invasive procedures. b. Before caring for clients at high-risk for infection. c. When there is prolonged or intense contact with the client (bathing the client). d. Between tasks on the same client. e. Before touching a wound. f. After removing gloves. g. After touching objects that are potentially</p>			

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	<p>contaminated. ... n. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Alternatively, wash hands with antimicrobial soap and water in all clinical situations. o. Decontaminate hands before having direct contact with clients, before donning sterile gloves to insert urinary catheters, ... p. Decontaminate hands after contact with client's intact skin, after contact with body fluids, excretions, non intact skin and wound dressings. ... r. Decontaminate hands after removing gloves. ... Hand Hygiene Technique ... 2. when washing hands with soap and water, ... rub hands together vigorously for at least twenty (20) seconds, covering all surfaces of hand and fingers."</p> <p>12. The agency's undated policy titled "Pressure Ulcer Dressing Change," # G-160, states, "Equipment/Supplies ... Gloves. (sterile and non sterile). ... Procedure ... 4. Put on gloves and remove old dressing and discard. ... 6. Apply new pair of gloves. ... 10. Cleanse the wound bed."</p> <p>13. The agency's undated policy titled "Intermittent Catheterization," # D-110, states, "Equipment/Supplies ... One pair of disposable gloves."</p>			

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N 518 Bldg. 00	<p>14. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <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 observation, and interview, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 1 of 6 home visit observations. (#1)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care 7/28/11, failed to evidence the patient had been provided an updated Advanced Directives document revised July 2013.</p> <p>On 5/8/15 at 9 AM, a home visit was conducted to patient #1. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p>	N 518	<p>A list has been developed that addresses all documents required to be in the home in order to be in full compliance with state and federal regulations. This includes a copy of the current Advanced Directive Law dated July 2013. All staff will be inserviced by June 17, 2015. on which documents must be present in the client's home file. RNCMs will complete a 100% audit</p>	06/17/2015

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N 522 Bldg. 00	<p>2. During interview on 5/6/15 at 12:20 PM, employee I, the administrator, indicated the agency has the current packet available.</p> <p>3. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure all visits were provided as ordered by the physician and failed to ensure any missed visits were communicated to the physician for 1 of 12 clinical records reviewed. (# 5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 1/30/06, contained a plan of care dated 3/23-5/21/15 with orders for skilled nurse</p>	N 522	<p>of all client home files by June 17, 2015, to ensure that all items are present in the home files. Ongoing compliance will be ensured by the RNCMs reviewing all clients files at every supervisory and/or skilled nurse visit. Clinical Director is responsible for ongoing compliance with this regulation.</p> <p>We will ensure all visits are provided as ordered by the physician and any missed visits will be communicated to the physician. By 5/22/15, client record #5 will be reviewed and the physician will be notified of the missed visits during the certification period 3/23/15-5/21/15</p>	06/17/2015

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	<p>(SN) 3 visits per day times 9 weeks and home health aide 3 hours each morning, noon, and evening 7 days a week for 9 weeks.</p> <p>The record failed to evidence the SN visits were completed as ordered for Noon visits on 3/26, 4/2, 4/9, and 4/23/15. The record failed to evidence any missed visit notifications to the physician.</p> <p>2. During interview on 5/11/14 at 3:20 PM, employee J, the nursing supervisor, indicated there are not Noon visits on those days because the patient sometimes goes to Turnstone. Employee J indicated this is the patient's choice to miss those times, so they do not need to notify the physician.</p> <p>The record failed to evidence documentation the patient had gone to Turnstone.</p> <p>3. The agency's undated and un-numbered policy titled "Clinical Documentation," states,"6. Services not provided and the reason for the missed visits will be documented and reported to the physician."</p> <p>4. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no</p>		<p>due to weekly attendance on Thursdays at Turnstone Center for Children and Adults with Disabilities. By 5/22/15, client record #5 will be amended to list Turnstone services on the client's Plan of Care (485) for coordination of care purposes. The Clinical Director will ensure ongoing compliance with this regulation.</p>	

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N 524 Bldg. 00	<p>further information to submit for review.</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. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>ased on clinical record review, policy review, and interview, the agency failed to ensure the plan of care (POC) contained accurate and complete information for 2 of 12 clinical records reviewed. (# 5, and 7)</p> <p>Findings include</p>	N 524	By 5/22/15, the 485s for Client #5 and #7 will be amended to include code status. By 6/17/15, the code status for all clients will be reflected on either the current 485 or a	06/17/2015

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	<p>1. Clinical record #5, start of care date (SOC) 1/30/06, contained a POC dated 3/23-5/21/15. The POC evidenced the SOC date as 10/3/06. The clinical record evidenced the client signed the services agreement form on 1/30/06.</p> <p>2. Clinical record #7, SOC date 4/13/15, contained a POC dated 4/13-6/11/15. The POC failed to evidence a code status.</p> <p>During interview on 5/11/15 at 11:55 AM, employee I, the administrator, indicated the code status is usually in the last section of the POC, but it is also on the admitting record face sheet, and a copy is also in the patient binders in their homes. Employee I indicated if the POC does not have a code status listed, the patients are considered a full code unless they or the physician specify otherwise.</p> <p>3. The agency's undated policy titled "Physician Orders," # C-635, states "All medications, treatments, that are part of the client's plan of care, must be ordered by a physician."</p> <p>4. The agency's undated policy titled "Comprehensive Client Assessment," # C-145, states "3. In addition to general health status/system management, Home Nursing Services comprehensive</p>		<p>physician's order. By 6/17/15, we will verify the SOC date for Client Record #5. Clinical records will be audited at certification time points through Soneto, our clinical records software program. Clinical Director will ensure ongoing compliance with this regulation.</p>	

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N 529 Bldg. 00	<p>assessment tool ... will include: ... m. Emergent care data."</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record review, and interview, the agency failed to ensure the 60 day summaries reflected changes in patient condition for 3 of 12 records reviewed. (# 2, 3, and 6)</p> <p>Findings include</p> <p>1. Clinical record # 2, start of care (SOC) date 3/4/13, contained a plan of care (POC) dated 2/22-4/22/15 with a 60 day summary that stated, "Client is having a decline in [their] abilities." This summary failed to identify the decline of abilities.</p> <p>The POC for the certification period</p>	N 529	<p>Clinical records will be audited to ensure that each sixty day summary is updated at each certification period to reflect the client's current status. As we transition to Electronic Health Records (EHRs), a process we began on 4/1/15, clients' 485s will require typing current summaries at each certification period.</p> <p>Soneto will not allow us to copy the summary from one certification period to the next. By 6/17/15, Clinical records #2, 3, and 6 will be updated to reflect the current condition of the client.</p> <p>These updated statements will be sent to the physician by 6/17/15. Sixty day summaries will be included in the audit at certification time points through Soneto, our clinical records</p>	06/17/2015

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	<p>4/23-6/21/15 60 day summary stated, "Client is having a decline in [their] abilities." This summary failed to identify the decline of abilities.</p> <p>2. Clinical record # 3, SOC date 10/27/14, contained a POC dated 2/24-4/24/15 with a 60 day summary that stated, "Currently the client has 5 pressure ulcers that require SN [skilled nurse] dressing changes daily."</p> <p>A. The POC dated 4/25-6/23/15 60 day summary stated, "Client has multiple pressure ulcers." This summary failed to identify how many more pressure ulcers the client developed or the status of the pressure ulcers.</p> <p>B. The clinical record evidenced the 5 pressure ulcers had improved.</p> <p>3. Clinical record # 6, SOC date 10/2/13, contained a POC dated 2/14-4/14/15 with a 60 day summary that stated, "Client is considered a fall risk ... and [client] has fallen recently." The clinical record failed to evidence the patient had fallen recently.</p> <p>The POC dated 4/15-6/13/15 60 day summary stated, "Client is considered a fall risk ... and has fallen recently." The clinical record failed to evidence the</p>		software program. Clinical Director will ensure ongoing compliance with this regulation.	

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N 546 Bldg. 00	<p>patient had fallen recently.</p> <p>4. During interview on 5/11/15 at 2:00 PM, employee J, the nursing supervisor, indicated she did not see any recent falls documented for patient #6, so she is not sure why the 60 day summary still says recent fall.</p> <p>5. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the physician was notified of patient discharge from the agency for 2 of 4 discharge records reviewed. (# 10, and 12)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care</p>	N 546	By 6/17/15, a discharge summary for Clinical Records #10 and #12 will be written and sent to the physician. By 6/17/15, all RN Case Managers were inserviced on required documentation at the time of client discharge. By 6/17/15, all discharged client records will be audited to ensure the physician was notified of discharge and sent a discharge summary. By 6/17/15, the Quality	06/17/2015

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	<p>(SOC) date 4/24/07, evidenced the patient was discharge on 3/24/15. The record failed to evidence physician notification of discharge, and failed to contain a discharge summary.</p> <p>2. Clinical record # 12, SOC date 6/27/14, evidenced the patient was discharged on 4/15/15. The record failed to evidence physician notification of discharge and failed to contain a discharge summary.</p> <p>3. During interview on 5/6/15 at 2:45 PM, employee I, the administrator, indicated there is not a discharge summary in the chart nor in the computer for both patients. Employee I indicated discharge summaries are to be sent to the physician when they are completed.</p> <p>4. The agency's undated policy titled "Client Discharge Process," # C-500, states, "5. The Registered Nurse shall review the clinical record to assure accuracy and completion. A Discharge Summary shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family. ... d. Documentation of all communication with the client, including the rationale for discharge, will be kept in</p>		Assurance Coordinator will audit 100% of discharged clinical records to ensure physician was notified of discharged and sent a discharge summary. By 6/17/15, the Clinical Director will ensure ongoing compliance with this regulation.	

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N 550 Bldg. 00	<p>the client file with copies sent to the primary physician."</p> <p>5. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. y. Discharge Instructions. 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, ... from admission to discharge."</p> <p>6. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) delegated tasks appropriately and within</p>	N 550	On 5/12/15, Employees C and E were notified by telephone to explain that Home Health Aides are	06/17/2015

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	<p>the scope of practice to the Home Health Aides (HHA) for 1 of 11 records reviewed of patients receiving HHA services. (#5)</p> <p>Findings include</p> <p>1. Clinical record # 5, start of care date 1/30/06, contained a plan of care dated 3/23-5/21/15 with orders for SN (skilled nurse) 3 visits each day for 9 weeks to assess vital signs and all body systems, ... Change colostomy wafer every 3-4 days and as needed for leakage, straight cath with 16 french three times a day, 7 days a week using clean technique, Administer eye drops 2 times daily and any other medications as needed. And, HHA 3 hours daily in AM 7 times a week, 2 hours daily midday 7 times a week, 3 hours daily PM 7 times a week for 9 weeks to assist with bathing, grooming, dressing, safe transfers with Hoyer lift, meal prep, feed client, remind client to take meds, change depends and toileting, empty colostomy bag as needed, do ROM [range of motion] of extremities, reposition client in wheel chair or bed as needed, equipment care, and any other personal care needs and ADLs (activities of daily living), as requested.</p> <p>A. The record evidenced three HHA</p>		<p>not permitted to perform tasks outside their scope. Client #5 was also notified on 5/12/15 by telephone (and by email) that Home Health Aides are not permitted to perform tasks outside their scope. On 5/12/15, all office staff were notified via email that Home Health Aides are not permitted to perform tasks outside their scope. By 5/15/15, all staff will be given a copy of our nurse delegation policy, prohibiting home health aides from administering medications or any other duty beyond their scope. By 6/17/15, the Home Health Aide Assignment Sheets for Client #5 will be updated to clearly indicate the specific, varied tasks for each shift of care provided. RNCMs will assess compliance</p>	

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	<p>Service Plans reviewed on 3/19/15, one for AM visits, one for Noon visits, and one for HS (hour of sleep) visits. Each service plan evidenced the RN assigned the HHA to the following tasks: "Change colostomy bag as needed. HHA can change wafer if checked off by RN [Registered Nurse]. Call RN after task done."</p> <p>B. The three HHA Service Plans contained all the same tasks for all three HHA visits including Tub/Shower, Bath-Partial/Complete, Assist with Dressing, Hair Care, Skin Care, check Pressure Areas, Shave/Groom/Deodorant, Nail Hygiene, Oral Care, Elimination Assist, Ostomy care, Assist with Medications (remind only), ambulation assist, mobility assist, range of motion passive and active, positioning, regular diet, meal preparation, assist with feeding, encourage fluids, grocery shopping, laundry, light house keeping, and equipment care.</p> <p>2. During interview on 5/11/15 at 1:50 PM, employee J, the nursing supervisor, indicated any HHA seeing patient #5 is checked off to perform the wafer and colostomy bag change. But the colostomy care means emptying, and there are enough nurses going to see the patient that the HHAs haven't had to change the</p>		during each present supervisory visit to ensure that the home health aide is operating within the scope of their certification. Clinical Director will ensure ongoing compliance with this regulation.	

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	<p>bag or the wafer, and if they did it would be documented in the comments section of their documentation.</p> <p>3. During interview on 5/11/15 at 2:05 PM, employee J indicated the agency consulted someone who told the agency the HHAs could change the colostomy bag and wafer as long as they were competenced on it by an RN.</p> <p>4. During employee file review on 5/12/15, employee file E, a HHA, evidenced an In-Service and training Report dated 6/25/14 with the topic "Changing colostomy wafer," and the summary section evidenced the check-off included "Observe skin around stoma, ... Call SN of changes in skin and or stoma."</p> <p>A. Employee file C also evidenced the agency competency evaluated the HHA for Aerosol Nebulizer.</p> <p>The "Aerosol Nebulizers Competency Evaluation" sheet dated 5/16 (no year specified) as the competency evaluation date, but the RN (employee T) dated it 4/15/15. This competency sheet performance criteria stated, "1. Checks physician orders and determines type of nebulizer/inhaler client is using ... 4. Prepares nebulizer by filling with prescribed amount of medication ... 6.</p>			

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	<p>Inserts mouthpiece or attaches adapter to begin administration."</p> <p>5. During interview on 5/11/15 at 9:50 AM, employee J, the nursing supervisor, indicated patient # 5 needs an inhaler and stated, "Our source said we can assign to the HHA as long as they are competencied by the RN."</p> <p>6. The agency's undated policy titled "Ostomy Care," # E-190, states, "Applies to: Registered Nurses, Licensed Practical/Vocational Nurses, Therapists. ... Procedure: ... 7. Assess skin condition."</p> <p>7. The agency's undated policy titled "Home Health Aide Assignment Sheet," # C-751, states, "2. The Assignment Sheet shall be developed in plain, non-technical lay terms and identify the duties to be performed, such as, but not limited to: ... d. Assistance with medications that are ordinarily self-administered."</p> <p>8. The agency's undated policy titled "Home Health Aide Services," # C-220, states, "The duties of a home health aide include the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in</p>			

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N 608 Bldg. 00	<p>administering medications that are ordinarily self-administered. ... Purpose: To abide by state/federal guidelines and offer guidelines to Home Nursing services staff, physicians, and community for the appropriate utilization of Home Health Aide services. Special Instructions- 1. Home Health Aide services may include: ... j. Assisting with medications, and other delegated nursing tasks as directed by the Registered Nurse and in accordance with state law and Home Nursing Services policy. ... 4. Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific State/Federal and Home Nursing Services policies."</p> <p>9. The agency's undated job description titled "Home Health Aide," # D-470, states, "4. Reminds the client in administration of medications that are ordinarily self-administered under the direction and supervision of a Registered Nurse."</p> <p>10. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current</p>			

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	<p>findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <ol style="list-style-type: none"> (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the accuracy of clinical records, including performance of tasks by home health aides (HHA), for 1 of 11 records reviewed of patients receiving HHA services (# 5) and failed to ensure each discharge record contained a discharge summary and discharge assessment for 2 of 4 discharge records reviewed. (# 10, and 12)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #5, start of care (SOC) date 1/30/06, contained a plan of care (POC) dated 3/23-5/21/15 with orders for SN (skilled nurse) 3 visits each day for 9 weeks, HHA 3 hours daily in AM 7 times a week, 2 hours daily midday 7 times a 	N 608	By 6/17/15, the Home Health Aide Assignment Sheets for Client #5 will be updated to clearly indicate the specific, varied tasks for each shift of care provided. By 6/17/15, all agency home health aides will be inserviced on proper documentation of tasks performed. By 6/17/15, all RN Case Managers will be inserviced on required documentation at the time of client discharge. By 6/17/15, all discharged client records will be audited to ensure the physician was notified of discharge and sent a discharge summary. By 6/17/15, the Quality Assurance Coordinator will audit 100% of discharged clinical records to ensure physician was notified of discharged and sent a discharge summary. By 6/17/15, 100% of home health aide documentation will be	06/17/2015

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	<p>week, and 3 hours daily PM 7 times a week for 9 weeks to assist with bathing, grooming, dressing, safe transfers with Hoyer lift, meal prep, feed client, remind client to take meds, change depends and toileting, empty colostomy bag as needed, do ROM [range of motion] of extremities, and reposition client in wheel chair or bed as needed, equipment care, and any other personal care needs and ADLs (activities of daily living) as requested.</p> <p>A. The three HHA Service Plans, reviewed on 3/19/15, contained all the same tasks for all three HHA visits including Tub/Shower, Bath-Partial/Complete, Assist with Dressing, Hair Care, Skin Care, check Pressure Areas, Shave/Groom/Deodorant, Nail Hygiene, Oral Care, Elimination Assist, Ostomy care, Assist with Medications (remind only), ambulation assist, mobility assist, range of motion passive and active, positioning, regular diet, meal preparation, assist with feeding, encourage fluids, grocery shopping, laundry, light house keeping, and equipment care.</p> <p>B. The HHA Weekly Visit Record for the dates 3/23-5/3/15, for all HHA shifts, failed to evidence which task was performed by the HHAs. The sections</p>		<p>audited by First Impressions Coordinator to ensure compliance with the assignment sheet. The Clinical Director and Administrator will ensure ongoing compliance with this regulation.</p>	

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	<p>titled "Tub/Shower, Bath-Partial/Complete, Hair Care- Brush, Shampoo/Other, Skin Care/Foot Care (Hygiene), Shave/Groom/Deodorant, Nail Hygiene- Clean/File/Report, Oral Care- Brush/Swab/Dentures, Ambulation Assist- WC/Walker/Cane, Limit/Encourage Fluids, and Light Housekeeping- Bedroom/Bathroom/Kitchen-Change Bed Linen" failed to evidence which tasks were performed by the HHAs.</p> <p>C. During interview on 5/11/15 at 1:55 PM, employee J, the nursing supervisor, indicated patient # 5 does not receive tub bathing.</p> <p>2. Clinical record # 10, start of care (SOC) date 4/24/07, evidenced the patient was discharged on 3/24/15. The record failed to contain a discharge summary.</p> <p>3. Clinical record # 12, SOC date 6/27/14, evidenced the patient was discharged on 4/15/15. The record failed to contain a discharge summary.</p> <p>4. During interview on 5/6/15 at 2:45 PM, employee I, the administrator, indicated there is not a discharge summary in the chart, nor in the computer for patients 10 and 12.</p>			

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	<p>5. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. y. Discharge Instructions. 3. When care is provided, documentation in the clinical record shall reflect the client's physical condition, ... from admission to discharge."</p> <p>6. The agency's undated policy titled "Home Health Aide: Documentation," no number, states, "Purpose- To provide documentation of the care performed by the Home Health Aide on each visit. ... Special Instructions- ... 3. The designated Registered Nurse or designated person is responsible for reviewing the Home Health Aide's charting before it is placed in the chart."</p> <p>7. The agency's undated policy titled "Clinical Records/Medical Record Retention," # C-870, states, "2. In addition to the Plan of Care, the clinical record may contain appropriate identifying information, including, but is not limited to: ... x. Discharge Summary. ... 3. When care is provided, documentation in the clinical record shall</p>			

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	<p>reflect the client's physical condition, psychosocial status, safety measures to protect the client from injury, and medical care provided, as applicable, from admission to discharge. ... 8. ... when a client is discharged from care, the clinical record shall be completed (including required summary, documentation, and signature) within an appropriate time frame (identified by the Home Nursing Services).</p> <p>8. On 5/12/15 at 11:42 AM, employee I, the administrator, indicated they had no further information to submit for review.</p>			