

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K083	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2015
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NAME OF PROVIDER OR SUPPLIER PURPOSE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5455 HARRISON PARK LANE STE B INDIANAPOLIS, IN 46216
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G 000 Bldg. 00	<p>This visit was for a home health agency federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 5-13, 5-14, 5-15, and 5-18-2015</p> <p>Facility Number: IN012769</p> <p>Medicaid Number: 201062790A</p> <p>Census Service Type: Unduplicated last 12 months Skilled: 62 Home Health Aide Only: 490 Personal Service Only: 0 (Not on license) Total: 552</p> <p>Current Census: Skilled: 50 Home Health Aide Only: 319 Personal Service Only: 0 (Not on license) Total: 369</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6</p>	G 000		

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 144 Bldg. 00	<p>Total: 12</p> <p>QR: JE 5/21/15</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on observation, policy review, clinical record (CR) review, and interview, the agency failed to ensure agency personnel maintained timely liaison with another agency providing services to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care for 1 of 3 CR reviewed of patients receiving services from another agency (3).</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Care", undated, states, "Purpose ... to establish effective interchange, reporting, and coordination of client care ... to</p>			G 144	<p>It is the Policy of this Agency that clinical records will contain documentation establishing effective interchange, reporting, and coordination of patient care.</p> <p>1. Clinical record for patient 3 was reviewed. Agency coordinated care for patient 3 with Attendant Care provider and documented coordination of care in clinical record.</p> <p>2. An audit of all clinical records of Active patients was completed. Care was coordinated for all patients receiving services from another Agency and documentation of Care Coordination was documented in patient clinical records.</p> <p>3. Agency Policy on Coordination of Services was reviewed and all Licensed</p>		06/15/2015

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G 159 Bldg. 00	<p>modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services ... to ensure continuity of care."</p> <p>2. On 5-14-15 at 4:00, during a home visit to patient 3, the patient indicated patient also receives attendant care services from another agency. The CR failed to evidence documentation of coordination of care between the 2 agencies.</p> <p>3. On 5-15-15 at 3:45 PM, Employee B, Nursing Supervisor, indicated the clinical record lacked evidence of ongoing communication between the two agencies. No further documentation was provided prior to exit.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure plans of care included specific</p>			G 159	<p>Nurses have been in-serviced on policy.</p> <p>4.Nursing Administration will audit clinicalrecord for each patient at a minimum of every 60 days at time recertificationvisit was completed to ensure Coordination of services was completed. Number ofpatient records audited, number of errors, and error percentage rate will bemonitored monthly in QAPI Program. Continuing education and in-servicing willbe conducted based on QAPI results. Audit will continue until 6 consecutivemonths of no negative findings.</p> <p>It is the policy of this Agency to develop a plan of carethat covers all pertinent diagnoses, including mental status, types of serviceand</p>		06/15/2015

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	<p>interventions with individualized measurable goals and discharge plan for 12 of 12 (1-12) records reviewed; included all durable medical equipment (DME) required for 2 of 12 (7, 11) records reviewed; and correctly identified the start of care (SOC) date and certification period (s) (CP) for 7 of 12 clinical records reviewed (1-6, and 12).</p> <p>Findings include:</p> <p>Regarding specific measurable goals and interventions:</p> <p>1. Policy "Care Plans", undated, states, "Each client will have a care plan that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals ... Purpose ... To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals ... The Care Plan shall include, but not be limited to: Reasonable, measurable, and realistic goals as determined by the assessment and client expectations ... Indicators for measuring goal achievement and identified time frames."</p> <p>2. Policy "Client Assessment/ Update</p>		<p>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>1. Clinical records were reviewed for 12 / 12 patients who were identified to be affected by deficient practice. Physician orders were obtained for 9 patients that clarified specific interventions with measurable goals, DC plans and Durable Medical equipment. Plan of Care was updated with physician orders. Patients 7, 10, and 11 have been discharged from services.</p> <p>2. An audit of all clinical records of Active patients was completed. All patient Plan of Care have been revised to contain specific interventions with measurable goals and discharge plans. Plan of Care have also been updated with all durable Medical Equipment.</p> <p>3. Agency Policy on Plan of Care was reviewed. All licensed nurses have been in-serviced on policy. Agency Admission Policy has been reviewed. All licensed nurses have been in-serviced on policy. Patient start of care dates will be defined as first billable visit.</p> <p>4. Nursing Administration will</p>	

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	<p>of Comprehensive Assessment", undated, states, "Discharge planning is initiated, goals are identified, and/or continuing care needs are recognized."</p> <p>3. CR 1, start of care (SOC) 4-8-15, contained a plan of care (POC) for the CP 4-8 to 6-6-15 with orders for home health aide (HHA) services to "assist with ADLs, [activities of daily living] Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>4. CR 2, SOC 3-9-15, contained a POC for the CP 5-8 to 7-6-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>5. CR 3, SOC 10-17-13, contained a POC for the CP 4-10 to 6-8-15 with orders for skilled nursing (SN) to assess body systems and vital signs PRN (as needed). SN to check blood glucose</p>		<p>audit clinical record for each patient at a minimum of every 60 days at time recertification visit was completed to ensure plan of care contains specific interventions with measurable goals, discharge plans, and Durable Medical Equipment. Number of patient records audited, number of errors, and error percentage rate will be monitored monthly in QAPI Program. Continuing education and in-servicing will be conducted based on QAPI results. Audit will continue until 6 consecutive months of no negative findings.</p>	

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	<p>level and administer insulin injections BID (twice a day) as ordered by MD. SN to fill mediplanner weekly." Goal was "Patient will receive medication as order by physician." The discharge plan was "when services are no longer needed."</p> <p>6. CR 4, SOC 5-2-13, contained a POC for the CP 4-22 to 6-20-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>7. CR 5, SOC 4-21-15, contained a POC for the CP 4-21 to 6-19-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>8. CR 6, SOC 6-12-14, contained a POC for the CP 4-8 to 6-6-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management</p>			

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	<p>needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>9. CR 7, SOC 10-2-13, contained a POC for the CP 3-16 to 5-24-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>10. CR 8, SOC 11-17-14, contained a POC for the CP 5-16 to 7-6-14 with orders for SN to assist with medication management and HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were- for SN "Patient will take medications as ordered by MD without adverse reaction" and for HHA- "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p>			

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	<p>11 CR 9, SOC 4-7-14, contained a POC for the CP 5-16 to 7-6-14 with orders for SN to "assess body systems and vital signs PRN. SN to check blood glucose level every visit and administer insulin as ordered by MD. SN to assess for signs and symptoms of hypo/hyperglycemia." The POC goals were "Patient's will receive medications as ordered by physician." The discharge plan was "when services are no longer needed."</p> <p>12. CR 10, SOC 6-10-14, contained a POC for the CP 2-5 to 4-5-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>13. CR 11, SOC 12-24-14, contained a POC for the CP 12-24-14 to 2-21-15 with orders for SN to " assist with med. management. Pre pour meds q [every] week and monitor for efficacy and potential adverse reaction. Report any complications or med. non compliance." HHA services to "assist with ADL and personal care needs. The goals were for SN - pt. will receive meds as ordered by physician and remain compliant with</p>			

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	<p>meds without adverse reaction" and for HHA "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>14. CR 12, SOC 4-10-15, contained a POC for the CP 4-10 to 6-8-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." Rehabilitation potential was "Fair." The discharge plan was "DC (discharge) when patient is independent with ADL's."</p> <p>15. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the goals and discharge plans for CR 1-12 were not individualized to the patient, specific, realistic, or measurable.</p> <p>Regarding DME:</p> <p>1. CR 7, SOC 10-2-13, contained a POC for the CP 3-16 to 5-24-15. Comprehensive assessment dated 10-13-13 evidenced patient has a</p>			

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	<p>tracheotomy the patient and caregiver perform suctioning of the tracheotomy as needed. The POC failed to evidence the suction machine as DME.</p> <p>2. CR 11, SOC 12-24-14, contained a POC for the CP 12-24-14 to 2-21-15. The comprehensive assessment dated 12-24-14 evidenced the patient used an electronic scooter. The POC failed to evidence the electronic scooter as DME.</p> <p>3. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the plans of care for CR 7 and 11 did not include all required equipment. The comprehensive assessments evidenced the patient used DME that was not identified on the POC.</p> <p>Regarding establishing the start of care date and certification period(s):</p> <p>1. Policy "Admission Policy", undated, states, "Purpose ... To provide guidelines for accepting clients for home health services to be provided in the client's place of residence that are clear to the home health staff, the medical and lay community, and that abide by state/federal guidelines ... Special Instructions ... Criteria for Admission ... At the initial visit the admitting nurse will assess the patient appropriateness or</p>			

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	<p>eligibility of services within 48 hours of receipt of a physician's order unless otherwise specified based on the following criteria: The patient is under the care of a physician for skilled services, the care needed is within the scope of the services provided by the home health agency, the home care services ordered are necessary and reasonable for treatment of the patient's illness or injury, the services can be provided safely and effectively in the home, the services will be rendered within the geographic service area of the agency, the services must meet the eligibility criteria established by the payer."</p> <p>2. CR 1, SOC (defined as 1st billable visit) 4-8-15, contained a POC for the CP 4-8 to 6-6-15 (The POC would begin when services are provided.) under Medicaid Prior Authorization (PA). The first billable visit, with care furnished, was by a home health aide (HHA) on 4-29-15, 21 days after the established start of care.</p> <p>3. CR 2, SOC 3-9-15, contained a POC for the CP 5-8 to 7-6-15 under Medicaid PA. The first billable visit, care furnished, was by HHA on 3-16-15, 7 days after date identified as the start of care.</p>			

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	<p>4. CR 3, SOC 10-17-13, contained a POC for the CP 4-10 to 6-8-15 under Medicaid PA . The first billable visit, care furnished, was by the skilled nurse (SN) on 11-4-13, 18 days after the date identified as the start of care.</p> <p>5. CR 4, SOC 5-2-13, contained a POC for the CP 4-22 to 6-20-15 under Medicaid PA. The SOC did not occur until after the date if the care plan. The first billable visit, care furnished, was by a HHA on 5-31-15, 29 days after the date identified as the start of care.</p> <p>6. CR 5, SOC 4-21-15, contained a POC for the CP 4-21 to 6-19-15 under Medicaid PA . The first billable visit, care furnished, was by a HHA on 5-6-15, 15 days after the date identified as the start of care.</p> <p>7. CR 6, SOC 6-12-14, contained a POC for the CP 4-8 to 6-6-15 under Medicaid PA. The first billable visit, care furnished, was by a HHA on 7-7-14, 25 days after the date identified as the start of care.</p> <p>8. CR 12, SOC 4-10-15, contained a POC for the CP 4-10 to 6-8-15, under Medicaid PA. The first billable visit, care furnished, was by a HHA on</p>			

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G 332 Bldg. 00	<p>4-16-15, 6 days after the date identified as the start of care.</p> <p>9. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the above patients were all under Medicaid PA. She indicated the agency practice is to designate the date of the comprehensive assessment as the start of care and hold services pending the approval of the Medicaid PA. She indicated when the PA approval is received, the agency then begins providing services for the client. She indicated the certification period ran from the agency established SOC and was not defined by the first billable visit. No further documentation was provided prior to exit.</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure patients received an initial assessment within 48 hours of referral, 48 hours of return home, or on the physician ordered start of care date for 8 of 12</p>	G 332	<p>It is the policy of this Agency that anInitial Assessment Visit will be held either within 48 hours of referral, 48hours of the patient's return home, or on the physician ordered start of caredate.</p> <p>1.Clinical records were</p>	06/15/2015	

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	<p>clinical records reviewed (1-7, and 12).</p> <p>Findings include:</p> <p>1. Policy "Admission Policy", undated, states, "Purpose ... To provide guidelines for accepting clients for home health services to be provided in the client's place of residence that are clear to the home health staff, the medical and lay community, and that abide by state/federal guidelines ... Special Instructions ... Criteria for Admission ... At the initial visit the admitting nurse will assess the patient appropriateness or eligibility of services within 48 hours of receipt of a physician's order unless otherwise specified based on the following criteria: The patient is under the care of a physician for skilled services, the care needed is within the scope of the services provided by the home health agency, the home care services ordered are necessary and reasonable for treatment of the patient's illness or injury, the services can be provided safely and effectively in the home, the services will be rendered within the the geographic service area of the agency, the services must meet the eligibility criteria established by the payer."</p> <p>2. Policy "Client Admission Process",</p>		<p>reviewed for patients 1-7& 12 who were identified to be affected by the deficient practice.Physician was notified and documentation of physician notification was placedin clinical records. Physician notification included date of referral and dateInitial Assessment Visit was conducted.</p> <p>2.An audit of all clinical records of Activepatients was completed. Physicians were notified and documentation of physiannotification was placed in clinical records for all patients whose initialassessment was not conducted within 48 hours of referral, 48 hours after returnhome, or on physician ordered start of care date.</p> <p>3.Agency Admission Policy and Agency ClientAdmission Policy were reviewed. All licensed nurses, Intake DepartmentPersonnel, and Community Service Representatives were in-serviced on policy.All referrals will receive an Initial Assessment Visit either within 48 hoursof referral, 48 hours of the patient's return home, or on the physician orderedstart of care date.</p> <p>4.Nursing Administration will audit all referralsand documentation of Initial Assessment Visit on a weekly basis. Number ofpatient referrals audited, number of errors, and error percentage rate will bemonitored monthly in QAPI Program. Continuing education</p>	

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	<p>undated, states, "Services will not be initiated until an initial assessment has been completed and identified client needs can be met by the agency."</p> <p>3. Clinical record (CR) 1, start of care (SOC) 4-8-15, referral date of 4-2-15, contained a plan of care (POC) for the certification period (CP) 4-8 to 6-6-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care date. The comprehensive assessment was completed 4-8-15.</p> <p>4. CR 2, SOC 3-9-15, referral date 3-9-15, failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care date. The comprehensive assessment was completed 3-9-15.</p> <p>5. CR 3, SOC 10-17-13, referral date 10-11-13, contained a POC for the CP 4-10 to 6-8-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care date. The comprehensive assessment was</p>		and in-servicing will be conducted based on QAPI results. Audit will continue until 6 consecutive months of no negative findings.	

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	<p>completed 10-17-13.</p> <p>6. CR 4, SOC 5-2-13, referral date 4-25-13, contained a POC for the CP 4-22 to 6-20-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care date. The comprehensive assessment was completed 5-2-13.</p> <p>7. CR 5, SOC 4-21-15, referral date 4-1-15, contained a POC for the CP 4-21 to 6-19-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care date. The comprehensive assessment was completed 4-21-15.</p> <p>8. CR 6, SOC 6-12-14, referral date 6-19-14, contained a POC for the CP 4-8 to 6-6-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care. The comprehensive assessment was completed 6-12-14.</p> <p>9. CR 7, SOC 10-2-13, referral date 9-30-13, contained a POC for the CP</p>			

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	<p>3-16 to 5-24-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care. The comprehensive assessment was completed 10-13-13.</p> <p>10. CR 12, SOC 4-10-15, referral date 4-3-15, contained a POC for the CP 4-10 to 6-8-15. The CR failed to evidence an initial visit was made to assess the patient's immediate care and support needs within 48 hours of referral or on the physician ordered start of care. The comprehensive assessment was completed 4-10-15.</p> <p>11. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the agency combines the initial assessment visit with the comprehensive assessment visit and the above patients did not have an initial assessment within 48 hours of referral or on the physician ordered start of care date. The nursing supervisor indicated CR 2 patient/family requested the agency come later than 48 hours after referral. No further documentation was provided prior to exit.</p>			

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G 334 Bldg. 00	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the comprehensive assessment was performed not more than 5 days after the start of care for 8 of 12 clinical records reviewed (1-7 and 12).</p> <p>Findings include:</p> <p>1. Policy "Comprehensive Client Assessment", undated, states, " A thorough, well-organized, and accurate assessment, consistent with the client's immediate needs will be completed for all clients in a timely manner, but no later than five (5) days after the start of care ... Purpose ... To identify clients medical, nursing, rehabilitative, social, and discharge planning needs ... Assessments are prioritized based on client need. All clients will have the Comprehensive Client Assessment completed within five (5) days of the initial visit."</p>	G 334	<p>It is the Policy of this Agency that a Comprehensive assessment will be completed in a timely manner, consistent with the patient's immediate needs but no later than 5 calendar days after the start of care.</p> <p>1. Clinical records were reviewed for patients 1-7 & 12 who were identified to be affected by the deficient practice. A Comprehensive Assessment has been conducted since start of care date to determine medical, nursing, rehabilitative, social, and discharge planning needs.</p> <p>2. An audit of all clinical records of Active patients was completed to ensure that all patients have had a Comprehensive Assessment.</p> <p>3. Agency Policy on Comprehensive assessments was reviewed. All licensed nurses have been in-serviced on the policy. All patients will have a Comprehensive assessment completed no later than 5 days after start of care date. Start of care date will be defined as the</p>	06/15/2015	

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	<p>2. Clinical Record (CR) 1, start of care (SOC) (defined as first billable visit) 4-8-15, contained a plan of care (POC) for the certification period (CP) 4-8 to 6-6-15. The SOC comprehensive assessment was dated 4-8-15, 21 days before the first billable visit on 4-29-15.</p> <p>3. CR 2, SOC 3-9-15, contained a POC for the CP 5-8 to 7-6-15. The SOC comprehensive assessment was dated 3-9-15, 7 days before the first billable visit on 3-16-15.</p> <p>4. CR 3, SOC 10-17-13, contained a POC for the CP 4-10 to 6-8-15. The SOC comprehensive assessment was dated 10-17-13, 18 days before the first billable visit on 11-4-13.</p> <p>5. CR 4, SOC 5-2-13, contained a POC for the CP 4-22 to 6-20-15. The SOC comprehensive assessment was dated 5-2-13, 29 days before the first billable visit on 5-31-13.</p> <p>6. CR 5, SOC 4-21-15, contained a POC for the CP 4-21 to 6-19-15. The SOC comprehensive assessment was dated 4-21-15, 15 days before the first billable visit on 5-6-15.</p> <p>7. CR 6, SOC 6-12-14, contained a</p>		<p>first billable visit.</p> <p>4. Nursing Administration will audit clinical records for all patients admitted on a weekly basis to ensure a Comprehensive Assessment has been completed within 5 days of Start of Care. Number of patient records audited, number of errors, and error percentage rate will be monitored monthly in QAPI Program. Continuing education and in-servicing will be conducted based on QAPI results. Audit will continue until 6 consecutive months of no negative findings.</p>	

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N 000	<p>POC for the CP 4-8 to 6-6-15. The SOC comprehensive assessment was dated 6-12-14, 25 days before the first billable visit on 7-12-14.</p> <p>8. CR 7, SOC 10-2-13, contained a POC for the CP 3-16 to 5-24-15. The SOC comprehensive assessment was dated 10-13-13, 11 days after first billable visit HHA visit on 10-2-13.</p> <p>9. CR 12, SOC 4-10-15, contained a POC for the CP 4-10 to 6-8-15. The SOC comprehensive assessment was dated 4-10-15, 6 days before the first billable HHA visit on 4-16-15.</p> <p>10. On 5-18-15 at 4:00 PM, the nursing supervisor indicated all the above CR were Medicaid prior authorization patients. No further documentation was provided prior to exit.</p>			

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Bldg. 00	<p>This visit was for a home health agency state relicensure survey.</p> <p>Survey Dates: 5-13, 5-14, 5-15, and 5-18-2015</p> <p>Facility Number: IN012769</p> <p>Medicaid Number: 201062790A</p> <p>Census Service Type: Unduplicated last 12 months Skilled: 62 Home Health Aide Only: 490 Personal Service Only: 0 (Not on license) Total: 552</p> <p>Current Census: Skilled: 50 Home Health Aide Only: 319 Personal Service Only: 0 (Not on license) Total: 369</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12</p>	N 000		

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N 486 Bldg. 00	<p>QR: JE 5/21/15</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on observation, policy review, clinical record (CR) review, and interview, the agency failed to ensure agency personnel maintained timely liaison with another agency providing services to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care for 1 of 3 CR reviewed of patients receiving services from another agency (3).</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Care", undated, states, "Purpose ... to establish effective interchange, reporting, and coordination of client care ... to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services ... to ensure continuity of care."</p> <p>2. On 5-14-15 at 4:00, during a home</p>	N 486	<p>It is the Policy of this Agency that clinical records will contain documentation establishing effective interchange, reporting, and coordination of patient care.</p> <p>1. Clinical record for patient 3 was reviewed. Agency coordinated care for patient 3 with Attendant Care provider and documented coordination of care in clinical record.</p> <p>2. An audit of all clinical records of Active patients was completed. Care was coordinated for all patients receiving services from another Agency and documentation of Care Coordination was documented in patient clinical records.</p> <p>3. Agency Policy on Coordination of Services was reviewed and all Licensed Nurses have been in-serviced on policy.</p> <p>4. Nursing Administration will audit clinical record for each patient at a minimum of every 60 days at time recertification visit</p>	06/15/2015

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N 524 Bldg. 00	<p>visit to patient 3, the patient indicated patient also receives attendant care services from another agency. The CR failed to evidence documentation of coordination of care between the 2 agencies.</p> <p>3. On 5-15-15 at 3:45 PM, Employee B, Nursing Supervisor, indicated the clinical record lacked evidence of ongoing communication between the two agencies. No further documentation was provided prior to exit.</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</p>		was completed to ensure Coordination of services was completed. Number of patient records audited, number of errors, and error percentage rate will be monitored monthly in QAPI Program. Continuing education and in-servicing will be conducted based on QAPI results. Audit will continue until 6 consecutive months of no negative findings.	

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	<p>treatment. (xiii) Any other appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure plans of care included specific interventions with individualized measurable goals and discharge plan for 12 of 12 (1-12) records reviewed; included all durable medical equipment (DME) required for 2 of 12 (7, 11) records reviewed; and correctly identified the start of care (SOC) date and certification period (s) (CP) for 7 of 12 clinical records reviewed (1-6, and 12).</p> <p>Findings include:</p> <p>Regarding specific measurable goals and interventions:</p> <p>1. Policy "Care Plans", undated, states, "Each client will have a care plan that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals ... Purpose ... To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals ... The Care Plan shall include, but not be limited to: Reasonable, measurable, and</p>	N 524	<p>It is the policy of this Agency to develop a plan of care that covers all pertinent diagnoses, including mental status, types of service 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>1. Clinical records were reviewed for 12 / 12 patients who were identified to be affected by deficient practice. Physician orders were obtained for 9 patients that clarified specific interventions with measurable goals, DC plans and Durable Medical equipment. Plan of Care was updated with physician orders. Patients 7, 10, and 11 have been discharged from services.</p> <p>2. An audit of all clinical records of Active patients was completed. All patient Plan of Care have been revised to contain specific interventions with measurable goals and discharge plans. Plan of Care have also been updated with all durable Medical Equipment.</p> <p>3. Agency Policy on Plan of Care was reviewed. All licensed nurses have been in-serviced on</p>	06/15/2015

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	<p>realistic goals as determined by the assessment and client expectations ... Indicators for measuring goal achievement and identified time frames."</p> <p>2. Policy "Client Assessment/ Update of Comprehensive Assessment", undated, states, "Discharge planning is initiated, goals are identified, and/or continuing care needs are recognized."</p> <p>3. CR 1, start of care (SOC) 4-8-15, contained a plan of care (POC) for the CP 4-8 to 6-6-15 with orders for home health aide (HHA) services to "assist with ADLs, [activities of daily living] Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>4. CR 2, SOC 3-9-15, contained a POC for the CP 5-8 to 7-6-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p>		<p>policy. Agency Admission Policy hasbeen reviewed. All licensed nurses have been in-serviced on policy. Patientstart of care dates will be defined as first billable visit.</p> <p>4.Nursing Administration will audit clinicalrecord for each patient at a minimum of every 60 days at time recertificationvisit was completed to ensure plan of care contains specific interventions withmeasurable goals, discharge plans, and Durable Medical Equipment. Number of patient records audited, number oferrors, and error percentage rate will be monitored monthly in QAPI Program.Continuing education and in-servicing will be conducted based on QAPI results.Audit will continue until 6 consecutive months of no negative findings.</p>	

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	<p>5. CR 3, SOC 10-17-13, contained a POC for the CP 4-10 to 6-8-15 with orders for skilled nursing (SN) to assess body systems and vital signs PRN (as needed). SN to check blood glucose level and administer insulin injections BID (twice a day) as ordered by MD. SN to fill mediplanner weekly." Goal was "Patient will receive medication as order by physician." The discharge plan was "when services are no longer needed."</p> <p>6. CR 4, SOC 5-2-13, contained a POC for the CP 4-22 to 6-20-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>7. CR 5, SOC 4-21-15, contained a POC for the CP 4-21 to 6-19-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer</p>			

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	<p>needed."</p> <p>8. CR 6, SOC 6-12-14, contained a POC for the CP 4-8 to 6-6-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>9. CR 7, SOC 10-2-13, contained a POC for the CP 3-16 to 5-24-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>10. CR 8, SOC 11-17-14, contained a POC for the CP 5-16 to 7-6-14 with orders for SN to assist with medication management and HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were- for SN "Patient will take medications as ordered by MD without adverse reaction" and for HHA- "Patient's</p>			

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	<p>ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>11 CR 9, SOC 4-7-14, contained a POC for the CP 5-16 to 7-6-14 with orders for SN to "assess body systems and vital signs PRN. SN to check blood glucose level every visit and administer insulin as ordered by MD. SN to assess for signs and symptoms of hypo/hyperglycemia." The POC goals were "Patient's will receive medications as ordered by physician." The discharge plan was "when services are no longer needed."</p> <p>12. CR 10, SOC 6-10-14, contained a POC for the CP 2-5 to 4-5-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>13. CR 11, SOC 12-24-14, contained a POC for the CP 12-24-14 to 2-21-15 with orders for SN to " assist with med. management. Pre pour meds q [every] week and monitor for efficacy and</p>			

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	<p>potential adverse reaction. Report any complications or med. non compliance." HHA services to "assist with ADL and personal care needs. The goals were for SN - pt. will receive meds as ordered by physician and remain compliant with meds without adverse reaction" and for HHA "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." The discharge plan was "when services are no longer needed."</p> <p>14. CR 12, SOC 4-10-15, contained a POC for the CP 4-10 to 6-8-15 with orders for HHA services to "assist with ADLs, Personal Care, and Home Management needs." The POC goals were "Patient's ADL and personal care needs will be met and patient will remain safe in the home for the length of the home health episode." Rehabilitation potential was "Fair." The discharge plan was "DC (discharge) when patient is independent with ADL's."</p> <p>15. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the goals and discharge plans for CR 1-12 were not individualized to the patient, specific, realistic, or measurable.</p>			

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	<p>Regarding DME:</p> <ol style="list-style-type: none"> CR 7, SOC 10-2-13, contained a POC for the CP 3-16 to 5-24-15. Comprehensive assessment dated 10-13-13 evidenced patient has a tracheotomy the patient and caregiver perform suctioning of the tracheotomy as needed. The POC failed to evidence the suction machine as DME. CR 11, SOC 12-24-14, contained a POC for the CP 12-24-14 to 2-21-15. The comprehensive assessment dated 12-24-14 evidenced the patient used an electronic scooter. The POC failed to evidence the electronic scooter as DME. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the plans of care for CR 7 and 11 did not include all required equipment. The comprehensive assessments evidenced the patient used DME that was not identified on the POC. <p>Regarding establishing the start of care date and certification period(s):</p> <ol style="list-style-type: none"> Policy "Admission Policy", undated, states, "Purpose ... To provide guidelines for accepting clients for home health services to be provided in the client's place of residence that are clear to the 			

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	<p>home health staff, the medical and lay community, and that abide by state/federal guidelines ... Special Instructions ... Criteria for Admission ...</p> <p>At the initial visit the admitting nurse will assess the patient appropriateness or eligibility of services within 48 hours of receipt of a physician's order unless otherwise specified based on the following criteria: The patient is under the care of a physician for skilled services, the care needed is within the scope of the services provided by the home health agency, the home care services ordered are necessary and reasonable for treatment of the patient's illness or injury, the services can be provided safely and effectively in the home, the services will be rendered within the the geographic service area of the agency, the services must meet the eligibility criteria established by the payer."</p> <p>2. CR 1, SOC (defined as 1st billable visit) 4-8-15, contained a POC for the CP 4-8 to 6-6-15 (The POC would begin when services are provided.) under Medicaid Prior Authorization (PA). The first billable visit, with care furnished, was by a home health aide (HHA) on 4-29-15, 21 days after the established start of care.</p>			

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	<p>3. CR 2, SOC 3-9-15, contained a POC for the CP 5-8 to 7-6-15 under Medicaid PA. The first billable visit, care furnished, was by HHA on 3-16-15, 7 days after date identified as the start of care.</p> <p>4. CR 3, SOC 10-17-13, contained a POC for the CP 4-10 to 6-8-15 under Medicaid PA . The first billable visit, care furnished, was by the skilled nurse (SN) on 11-4-13, 18 days after the date identified as the start of care.</p> <p>5. CR 4, SOC 5-2-13, contained a POC for the CP 4-22 to 6-20-15 under Medicaid PA. The SOC did not occur until after the date if the care plan. The first billable visit, care furnished, was by a HHA on 5-31-15, 29 days after the date identified as the start of care.</p> <p>6. CR 5, SOC 4-21-15, contained a POC for the CP 4-21 to 6-19-15 under Medicaid PA . The first billable visit, care furnished, was by a HHA on 5-6-15, 15 days after the date identified as the start of care.</p> <p>7. CR 6, SOC 6-12-14, contained a POC for the CP 4-8 to 6-6-15 under Medicaid PA. The first billable visit, care furnished, was by a HHA on 7-7-14, 25 days after the date identified as the</p>			

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N 610 Bldg. 00	<p>start of care.</p> <p>8. CR 12, SOC 4-10-15, contained a POC for the CP 4-10 to 6-8-15, under Medicaid PA. The first billable visit, care furnished, was by a HHA on 4-16-15, 6 days after the date identified as the start of care.</p> <p>9. On 5-18-15 at 4:00 PM, the nursing supervisor indicated the above patients were all under Medicaid PA. She indicated the agency practice is to designate the date of the comprehensive assessment as the start of care and hold services pending the approval of the Medicaid PA. She indicated when the PA approval is received, the agency then begins providing services for the client. She indicated the certification period ran from the agency established SOC and was not defined by the first billable visit. No further documentation was provided prior to exit.</p> <p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on policy review, clinical record review, and interview, the agency failed</p>	N 610	It is the policy of this Agency that all clinical records containing past and current findings in accordance with acceptable professional standards	06/15/2015

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	<p>to ensure the clinical record contained only visit notes that were correctly dated for 1 of 12 clinical records reviewed (5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Policy " Clinical Documentation", undated, states, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the client's care ... Purpose ... to ensure there is an accurate record of the services provided, client response, and ongoing need for care." 2. Clinical record 5, start of care 4-21-15, contained a plan of care for the certification period 4-21 to 6-19-15. The clinical record contained a home health aide visit note with entries dated 4-5, 4-6, 4-7, and 4-8-15, prior to the start of care and beginning of the certification period. 3. On 5-15-15 at 3:45 PM, the nursing supervisor indicated the home health aide had incorrectly dated the visit notes with dates prior to the start of care (4-2015), and the visits had been made 5-5, 5-6, 5-7, and 5-8-15. She indicated this home health aide is usually reliable and accurate with documentation. No further documentation was provided prior to 		<p>shall be maintained for every patient. All entries must be legible,clear, complete, and appropriately authenticated and dated.</p> <ol style="list-style-type: none"> 1.Clinical record for patient 5 was reviewed. HomeHealth Aide visit note with inaccurate dates has been corrected by the HomeHealth Aide in accordance with Agency Policy on Changes to Documentation inMedical Record to reflect accurate service dates of 5/5/15, 5/6/15, 5/7/15, and5/8/15. 2.An audit of all clinical records of Activepatients was completed to ensure that clinical documentation of all Home Healthaide visit notes are legible, clear, complete, and appropriately authenticatedand dated. 3.Agency Policy on Clinical Records has beenreviewed. The Home Health Aide identified in the deficient practice has beenin-serviced on Agency policy of Clinical Documentation. 4.Nursing Administration will audit all HomeHealth Aide Visit Records on a weekly basis. Number of patient records audited,number of errors, and error percentage rate will be monitored monthly in QAPIProgram. Continuing education and in-servicing will be conducted based on QAPIresults. Audit will continue until 6 consecutive months of no negativefindings. 	

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