

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/20/2015
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NAME OF PROVIDER OR SUPPLIER  AT HOME QUALITY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 751 E PORTER AVENUE, SUITE 9 CHESTERTON, IN 46304
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G 000  Bldg. 00	<p>This visit was for a home health federal recertification survey. This was an extended survey.</p> <p>Survey date: February 16 - 20, 2015</p> <p>Facility #: 008247</p> <p>Medicaid vendor #: 200839240</p> <p>Surveyor: Ingrid Miller, PHNS, RN Tameka Warren, PHNS, RN</p> <p>At Home Quality Care is precluded from providing its own training and competency evaluation program for a period of 2 years beginning February 20, 2015, to February 20, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.30 Skilled Nursing Services and 484.52 Evaluation of the Agency's Program.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 3, 2015 and March 5, 2015</p>	G 000		
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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 101  Bldg. 00	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.	G 101	<b>Agency Response:</b> This deficiency was addressed at a mandatory all staff in service on 3/11/2015 and included the necessity to ensure all signed and dated (including Patient Rights) documents are in the patient's home folders prior to providing care at the initial home visit. Staff have been instructed to check patient home folders with each visit and re-educate patient and family on the importance of maintaining all documents in the folder. The information will be provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts fail to contain the information. Education of staff was/will be completed 3.11.15 Patient Home folders will be brought current and complete by 3.25.15 <b>Measures To Ensure Future Compliance:</b> The Administrator has developed a checklist titled "State Compliance/Quality Assurance Audit Tool " that includes a review of all newly created home admission packets. Immediate action will include a 100% review of all home folders conducted by	03/11/2015

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G 110 Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>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>	G 110	<p>the nursing staff to ensure current compliance, and a 20% review each quarter there after. The expectation is for all nursing staff will check the folders for completion at each visit to maintain compliance. Failure to do so may result in disciplinary action, up to and including termination of employment.</p> <p><b>Person Responsible:</b> Administrator</p> <p><b>Agency Response:</b> This deficiency will be remedied immediately by providing a currently acceptable copy of the Indiana Advance Directives to all patients. The agency professional staff will ensure all patients receive the updated format with an explanation of its contents, that contains a description of the applicable State law. The information will be</p>	03/25/2015

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G 112 Bldg. 00	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The HHA must advise the patient of the agency's policies and procedures regarding disclosure of clinical records.	G 112	provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts fail to contain the mandated information. <b>Measures To Ensure Future Compliance:</b> All of the previous forms of the documents have been destroyed and the new forms are now contained in each new patient folder. The Administrator has developed a Quality Assurance document that includes a regular check of all newly developed patient folders to ensure ongoing compliance. Document titled, "State Compliance/Quality Assurance Monthly Audit Post Survey 2015". Immediate action will include a 100% review of all home folders conducted by the nursing staff to ensure current compliance, and a 20% review each quarter thereafter. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/25/2015 and ongoing  <b>Agency Response:</b> This deficiency will be remedied immediately by providing a copy of the agency Notice of Privacy Practices to all patients. All staff will receive in service information	03/25/2015	

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			<p>on the importance of this issue at the 3/11/2015 all staff mandatory in service. The information will be provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts do not contain the information.</p> <p><b>Measures To Ensure Future Compliance:</b> The agency professional staff will deliver and ensure all current patients receive the document as required to include signed and dated "Notice of Privacy Practice And General Privacy" and "Patient Acknowledgement And Consent" forms. The professional staff will educate patients and families on the importance of maintaining all information provided in the patient home folders. In addition, the professional staff will review the patient folder each visit to ensure ongoing agency compliance. The administrator will review all new patient folders to ensure all documents are included in the new patient home folders. "State Compliance/Quality Assurance Monthly Audit Tool Post Survey 2015" will be utilized with immediate action that will include a 100% review of all home folders conducted by the nursing staff to ensure current compliance, and a 20% review each quarter there after.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> 3/25/2015 and ongoing</p>	

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G 121  Bldg. 00	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.	G 121	<b>Agency Response:</b> A mandatory all staff in service was held 3/11/2015 and included information and policy review of agency's infection control policy for safe hand hygiene. The Administrator will initiate annual home health supervisory visits for all staff with an emphasis on infection control to include hand hygiene and the prevent the spread of infection. <b>Measures To Ensure Future Compliance: Responsible person:</b> Administrator will ensure that annual staff evaluations include home visits for patient care observation with a focus on issues of infection control. The current employee observation form titled, "Observation" will be utilized in this process. Infection control findings and issues will be further discussed and presented at the all staff mandatory meeting on 3/11/2015. <b>Date Completed :</b> 3.11.15 <b>Responsible person:</b> Administrator	03/11/2015
G 137  Bldg. 00	484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator.			

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G 137	<p>Based on agency document review, department document review, and interview, the agency failed to ensure a qualified person was functioning as the alternate administrator for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. A review of the agency documents failed to evidence the appointment of an alternate administrator after the resignation of Employee I, alternate administrator on 8/15/15.</li> <li>2. An agency document with a date of 11/25/14 evidenced Employee I had resigned on 8/15/14. This document was notification to the state about the alternate administrator resignation.</li> <li>3. On 2/19/15 at 12:05 PM, Employee G, administrator, indicated no one was authorized to be the alternate administrator.</li> <li>4. A review of Indiana State Department of Health documents evidenced no alternate administrator had been in place with the agency since August 15, 2014.</li> </ol>		<p><b>Agency Response:</b> Immediate action was taken regarding this delinquency. The Department has been notified regarding the approval of the alternate administrator and necessary documents. The Agency has received approval <b>Measures To Ensure Future Compliance:</b> The agency will ensure that all required documents are completed and returned and will maintain ongoing communication with the Department when there are questions or concerns related to current status of submitted information. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/20/2015 and ongoing</p>	03/20/2015
G 141	484.14(e)			

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Bldg. 00	<p><b>PERSONNEL POLICIES</b></p> <p>Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure the personnel policies were followed in 7 of 12 employee files reviewed (A - E, L and M).</p> <p>Findings</p> <p>1. The policy titled "Employee Physical" with a date of 7/3/06 stated, "to meet guidelines set by the state ... all employees with patient contact are required to have a pre - employment physical which will include a TB [tuberculosis] skin test [Mantoux] and / or chest xray ... Physicals done up to 12 months [180 days] in Indiana prior to hire date will be acceptable. the exam must be completed by 15 days past the hire date. These results have to be in writing, dated and signed by the examining physician and placed in the employee file. A TB skin test will be given on hire, or a negative chest x - ray report must be submitted. Thereafter a yearly TB skin test is required."</p>	G 141	<p><b>Agency Response:</b> 100% of all current patient care employee personnel files will be reviewed for accuracy and compliance. Any deficiencies will be corrected, brought current and documented in the records. <b>Measures To Ensure Future Compliance:</b> After completion of 100% audit of current patient care employee files , a audit tool will be utilized (or electronic tracking when available) for all new hires regarding mandatory requirements for personnel files. All direct care providers who are not current with their physical examinations (to include statement of communicable diseases), tuberculin skin testing/X-ray/screening tool (as applicable) will not be allowed to provide direct care until they are in compliance. All new hire folders will include the required medical information prior to direct patient care and reviewed and approved by the Administrator. Until the anticipated electronic personnel files and tracking are available a audit tool specifically for use in ensuring compliance for personnel files will be used to review 100% of personnel files by</p>	03/20/2015

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	<p>2. The policy titled "Job Descriptions" with a date of April 2012 stated, "A job description will be developed for each position in the organization ... at the time of hire, each individual will receive and sign a job description specific to his / her position."</p> <p>3. The file of Employee A, date of hire (DOH) 1/30/15 and first patient contact 1/30/15, Registered Nurse, failed to include a signed job description in the file.</p> <p>4. The file of Employee B, physical therapist, DOH 11/4/09 and first patient contact 11/11/09, failed to include a signed job description.</p> <p>5. The file of Employee C, physical therapy assistant, DOH 9/1/13 and first patient contact, 12/6/13 failed to include a dated job description in the personnel file.</p> <p>6. The file of Employee D, licensed practical nurse, DOH 12/17/12 and first patient contact 1/1/13, failed to include an annual tuberculosis test. A two step was completed 8/30/13.</p> <p>7. The file of Employee E, Registered Nurse, DOH 5/1/13 and first patient</p>		<p>March 20,2015<b>Responsible person:</b> Administrator <b>Date complete:</b> 3.20.15 and ongoing</p>	

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G 152 Bldg. 00	<p>contact 5/13/13, failed to include an annual tuberculosis screening.</p> <p>8. The file of Employee L, Home health aide (HHA) , DOH 6/13/14 and first patient contact 7/11/14, failed to include a physical exam</p> <p>9. The file of Employee M, HHA, DOH 12/16/13 and first patient contact 12/24/13, failed to include a physical exam and a job description.</p> <p>10. On 2/19/14 at 12 Noon, the administrator indicated the personnel files were not complete and she would look for the missing documents.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel was formed to act</p>	G 152	<b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted March 2015. The meeting will include the required attendees, including a physician. The	03/20/2015

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	<p>as the advisory committee (PAC) and met quarterly and that included representation of a physician and other disciplines that provided services on behalf of the agency for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records included a document titled "At Home Quality, Annual Professional Advisory Review for 2013", dated Feb, 2014. The document fails to evidence a practicing physician was in attendance at the meeting.</li> <li>2. A document titled "Professional Advisory Group Members" from 2014, failed to evidence a sign in sheet, to record attendance. Therefore, it was unable to be determined if the appropriate people attended the meetings.</li> <li>3. No other meetings were held other than the February, 2014 dated meeting. The administrative record failed to evidence quarterly PAC meetings by the agency.</li> <li>4. On 2/20/15 at 4:00 PM, Employee G, administrator indicated a PAC meeting would be held this month February, 2015 to review last year 2014 and the PAC meeting are only held yearly not</li> </ol>		<p>meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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G 153 Bldg. 00	<p>quarterly.</p> <p>5. The agency policy titled "Professional Advisory Committee" dated April 2012, states, " ... The committee will meet quarterly, or more often as needed, and minutes of each meeting will be recorded ... 1. Responsibilities of the Professional Advisory Committee include: ... C. Medical supervision and plans of care ... G. Personnel qualifications H. Annual program evaluation ... ."</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel was formed to act as the advisory committee (PAC) that</p>	G 153	<b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted March 2015. The meeting will include the required attendees,	03/20/2015

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	<p>included representation of a physician and other disciplines that provided services on behalf of the agency for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>The agency's administrative records included a document titled " At Home Quality, Annual Professional Advisory Review for 2013", dated February 2014. The document failed to evidence a practicing physician was in attendance at the meeting.</li> <li>A document titled "Professional Advisory Group Members" from 2014, failed to evidence a sign in sheet, to record attendance. Therefore, it was unable to be determined if the appropriate people attended the meetings.</li> <li>On 2/20/15 at 4:00 PM, Employee G, administrator, indicated a PAC meeting would be held this month February, 2015 to review last year 2014.</li> <li>The agency policy titled "Professional Advisory Committee" dated April 2012, states, " ... The committee will meet quarterly, or more often as needed, and minutes of each meeting will be recorded ... 1. Responsibilities of the Professional Advisory Committee include: ... C.</li> </ol>		<p>including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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G 154 Bldg. 00	<p>Medical supervision and plans of care ... G. Personnel qualifications H. Annual program evaluation ... "</p> <p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel was formed to create an advisory committee (PAC) and met quarterly to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records included a document titled " At Home Quality, Annual Professional Advisory</p>	G 154	<p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015</p>	03/20/2015

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	<p>Review for 2013", dated Feb, 2014. The document fails to evidence a practicing physician was in attendance at the meeting.</p> <p>2. A document titled "Professional Advisory Group Members" from 2014, failed to evidence a sign in sheet, minutes, and the exact date of the meeting.</p> <p>3. No other meetings were held other than the Feb, 2014 dated meeting. The administrative record failed to evidence quarterly PAC meetings by the agency.</p> <p>4. On 2/20/15 at 4:00 PM, Employee G, administrator indicated a PAC meeting would be held this month, February, 2015 to review last year 2014 and that the PAC meeting are only held yearly not quarterly.</p> <p>5. The agency policy titled "Professional Advisory Committee" dated April 2012, states, " ... The committee will meet quarterly, or more often as needed, and minutes of each meeting will be recorded ... 1. Responsibilities of the Professional Advisory Committee include: ... C. Medical supervision and plans of care ... G. Personnel qualifications H. Annual program evaluation ... ."</p>		<p>quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015. <b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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G 155 Bldg. 00	<p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's meetings are documented by dated minutes. Based on administrative record, agency policy review and interview, the agency failed to ensure a group of professional advisory committee (PAC) was formed and met quarterly that included representation of a physician and other disciplines that provided services on behalf of the agency for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records included a document titled "At Home Quality, Annual Professional Advisory Review for 2013", dated February 2014. The document fails to evidence a practicing physician was in attendance at the meeting.</li> <li>2. A document titled "Professional Advisory Group Members" from 2014, failed to evidence a sign in sheet, minutes, and the exact date of the meeting.</li> <li>3. No other meetings were held other than the February 2014 dated meeting. The administrative record failed to evidence quarterly PAC meetings by the agency.</li> </ol>	G 155	<p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	03/20/2015
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G 159 Bldg. 00	<p>4. On 2/20/15 at 4:00 PM, Employee G, administrator indicated a PAC meeting would be held this month February, 2015 to review last year 2014 and that the PAC meeting are only held yearly not quarterly.</p> <p>5. The agency policy titled "Professional Advisory Committee" dated April 2012, states, " ... The committee will meet quarterly, or more often as needed, and minutes of each meeting will be recorded ... 1. Responsibilities of the Professional Advisory Committee include: ... C. Medical supervision and plans of care ... G. Personnel qualifications H. Annual program evaluation ... ."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure the plan of care (POC) covered all pertinent</p>	G 159	<b>Agency Response:</b> The records will be updated for 4 patients whose plan failed to include all necessary DME's, accurate orders and pertinent diagnoses.	03/20/2015			

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	<p>diagnosis and durable medical equipment for 6 of 8 record reviewed with the potential to affect all the agency's current patients.</p> <p>Findings</p> <p>1. Home Visit observation on 2/16/15 at 3:10 AM to patient #1 noted durable medical equipment (DME) supplies present in the home included wound care supplies.</p> <p>Clinical record of patient # 1, Start of Care (SOC) 2/5/15, the plan of care (POC) for the certification period 2/5/15 to 4/5/15 failed to include wound care DME supplies.</p> <p>2. Home Visit observation on 2/17/15 at 9:10 AM to patient #3 noted documentation regarding Chronic Kidney Disease, stage 3 and DME supplies present in the home were shower seat and pulse oximeter.</p> <p>A. Interview with patient #3 on 2/17/15 at 9:40 AM, patient stated being treated for stage 3 Chronic Kidney Disease and agency is aware of the diagnosis.</p> <p>B. Clinical record of patient # 3, included a plan of care for the certification period 1/28/15 to 3/28/15 that failed to list</p>		<p><b>Measures To Ensure Future Compliance:</b> All staff inservice on 3/11/2015 includes expectation to include all DME's, accurate wound orders and pertinent diagnoses on assessment for incorporation into the POC. In addition, the Administrator will utilize a QA tool that addresses compliance with DME's, pertinent diagnoses, accurate orders on POC's and will add necessary DME's, orders and diagnoses to the out of compliance POC's. Future compliance will be addressed using QA tool for all new patient's. Tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015", for 20% of patients quarterly.</p> <p><b>Responsible person:</b> Administrator <b>Completed:</b> begin audits by 3.20.15 and ongoing</p>	

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	<p>Chronic Kidney Disease, stage 3 as a diagnosis and failed to include DME supplies.</p> <p>C. The administrator, employee G, on 2/19/15 at 3:50 PM, agreed that Chronic Kidney Disease, stage 3, should have been listed on the POC as a diagnosis and DME supplies should have been listed on the POC.</p> <p>3. Home visit observation on 2/17/15 at 11:00 AM to patient #4, noted DME present in the patient's home that included a shower chair, safety toilet seat, walker and rolling seated walker.</p> <p>Clinical record of patient # 4, SOC 1/19/15, included a plan of care for the certification period 1/19/15 to 3/19/15 that failed to include shower chair, safety toilet seat, walker and rolling seated walker.</p> <p>4. Home Visit observation on 2/18/15 at 10:10 AM to patient #5 noted DME supplies present in the home included hospital bed, pressure relieving mattress, wheelchair, wound vac, and wound care supplies.</p> <p>Clinical record of patient # 5, SOC 12/11/14, included a plan of care for the certification periods 12/11/14 to 2/8/15</p>			

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	<p>and 2/9/15 to 4/9/ that failed to include the DME supplies of hospital bed, pressure relieving mattress, wheelchair, wound vac, and wound care supplies.</p> <p>5. Clinical record of patient # 6, SOC 3/30/14, included a plan of care for the certification period 1/24/15 to 3/24/15 that stated, "Skilled Nursing: ... Provide wound care as ordered ... ." The POC failed to list exact wound care orders from physician and the family performs all wound care.</p> <p>6. Clinical record of patient # 8, SOC 12/15/14, included a plan of care for the certification period 12/15/14 to 2/12/15 that failed to evidence the patient ambulates with walker and walker is present in home during staff assessments. The POC failed to include this DME.</p> <p>7. The agency policy titled "Initial and Comprehensive Assessment", dated April 2012, stated, "Purpose: To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of care ... 3. ... all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented ... L. Equipment presently in the home and potentially needed by the patient ... ."</p>			

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G 164 Bldg. 00	<p>8. Agency policy titled "Care Planning Process", dated April 2012, stated "The clinical plan of care includes: ... L. Supplies and equipment required ... ."</p> <p>9. During interview with Nursing Supervisor on 2/19/15 at 4:10 PM, the Nursing Supervisor indicated the plans of care failed to include all medical equipment in patient's homes as required by policy.</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, interview, and review of policy and procedures, the agency failed to ensure notified the physician of changes in condition in 3 of 11 clinical records review with patient #1, #5, #6, creating the potential to affect any patients cared for by employee E, Registered Nurse (RN), employee B, Physical Therapist (PT) and employee G, Administrator RN, with the potential to affect all patients receiving services from the agency. Findings:</p>	G 164	<b>Agency Response:</b> Immediate action was taken at time of survey to ensure patients identified received appropriate care and physicians were aware of the change in condition. A all staff inservice was held 3/11/2015 to include information and policy review and regulatory compliance for physician notification, assessing and addressing patient condition change, infection, patient/family complaint of pain, the need to fully assess wound care, including calf measurements, pedal and dorsal pulses and to promptly report changes, including infection issues to the physician. It is also	03/11/2015

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	<p>Patient #1's clinical record, start of care (SOC) 2/5/15, certification period 2/5/15-4/5/15, failed to show the physician was notified of a pain level of 8, from employee B, PT, to inform the physician of signs and symptoms of infection present to right calf and pain level of 8 during PT Evaluation on 2/10/15.</p> <p>A. The record failed to show the physician was notified of changes in condition, from employee E, RN, to inform the physician of signs and symptoms of infection present to right calf and pain level of 10. Observation at home visit on 2/16/15 at 3:20 PM of patient #1 with employee E, RN, noted signs and symptoms of infection to right calf and patient expressed a pain level of 10.</p> <p>B. Interview on 2/19/15 at 2:50 PM, the administrator, employee G, agreed that employee E, RN should have notified the physician of changes in the patient's condition.</p> <p>C. Interview on 2/19/15 at 3:10 PM, employee E, RN agreed the physician should have been notified of changes in the patient's condition.</p>		<p>expected that the staff fully address and educate patient/family regarding their concerns related to their care and the process of that care, monitoring patient response to treatment and the need for staff to notify the physicians of staff and patient/family changes in conditions. <b>Measures To Ensure Future Compliance:</b> In addition to ongoing in services related to the plan of correction, the Administrator will utilize a compliance tool addressing each finding on the QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015" for 20% of all active patients quarterly <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	

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	<p>2. Clinical record #5, SOC 12/11/14, certification periods 12/11/14 to 2/8/15 and 2/9/15 to 4/9/15 included a clinical visit note dated 2/18/15 by employee D, licensed practical nurse (LPN), shows notification to supervisor, administrator, employee G, informing of signs and symptoms of infection present to both toe wounds. Clinical record failed to evidence, employee G, administrator, notified physician of signs and symptoms of infection to toe wounds. Observation during home visit on 2/18/15 at 10:00 AM of patient #5 with employee D, LPN, identified signs and symptoms of infection of wounds to right great toe and left second toe noted by LPN.</p> <p>On 2/19/15 at 11:50 AM, the administrator, employee G, agreed the physician should have been notified of changes in the patient's condition regarding SN visit on 2/16/15 at 10:00 AM.</p> <p>3. Clinical record #6, SOC 3/30/14, certification period 1/24/15 to 3/24/15, failed to evidence the physician was notified by employee G, administrator, after being informed of a skilled nurse SN visit note dated 2/3/15 where the LPN, employee D, noted "One fluid-filled blister to B. [both] feet near 5th toes. Band-aids to both."</p>			

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	<p>On 2/20/15 at 2:50 PM, the administrator, employee G, indicated the physician was not notified of the blisters because the family did not want the nurse to call a certain physician, who was not listed on the plan of care. When asked, why the physician listed on the plan of care was not notified, the administrator stated that physician was a cardiologist and not the primary physician. When asked why the primary physician was not listed on the plan of care, the administrator shrugged.</p> <p>4. The agency's policy titled "Ongoing Assessments" dated April 2012 states, "... During each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit thereafter ... C. Pain status when applicable ... B. Changes in patient condition ... ."</p> <p>5. The agency's policy titled "Monitoring Patient's Response/ Reporting to Physician" dated April 2012 states, "... Purpose : To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician ... A. Significant changes to the patient's condition ... F. When there is a problem implementing the plan of care ... ."</p>			

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G 168 Bldg. 00	<p>6. The agency's policy titled "Wound Management" dated 5/1/02 states, " ... 6. All assessment information will be documented and significant changes (e.g., fever, signs/symptoms of infection, increase in wound area or bleeding) will be communicated to the treated physician ... ."</p> <p>7. The agency's policy titled "Care Planning Process" dated April 2012 states, " ... 10. Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ... "</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on observation, interview, and review of procedures, it was determined the agency failed to ensure the registered nurse, employee E, provided care in accordance with the plan of care in home visit observation with patient #1 completed creating the potential to affect any patient cared for by Employee E, registered nurse (See G 170), failed to ensure the registered nurse included pertinent safety measure where noted on the plan of care for 2 of 11 records</p>	G 168	<p><b>Agency Response:</b> Employee E failed to follow MD orders for 3 patients. This employee will receive counsel and 1:1 education. Failure to comply in the future may result in further disciplinary action. <b>Measures To Ensure Future Compliance:</b> The administrator will monitor notes for compliance with MD orders. An inservice was held on 3/11/2015 that included education on the necessity and requirements to follow physician orders or contact physician for issues that may indicate a need to alter the plan of care. In</p>	03/11/2015

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G 170 Bldg. 00	<p>reviewed with the potential to affect all of the agency's patients (See G 175), and failed to ensure the registered nurse addressed the patient's concern regarding his/her wounds to affect any patient cared for by Employee E, registered nurse (See G 177).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.30 Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on observation, interview, and review of procedures, the agency failed to ensure the registered nurse, employee E, provided care in accordance with the plan of care in home visit observation with patient #1 completed creating the potential to affect any patient cared for by Employee E, registered nurse.</p> <p>Findings</p> <p>1. Home visit observation made on 2/16/15 at 3:10 PM to patient #1, with employee E, Registered Nurse.</p> <p>A. Observed employee E, registered</p>	G 170	<p>addition, the Administrator will conduct 1:1 home visits with all employees to ensure compliance to regulatory standards of care. The Administrator will utilize agency form titled, "Observation". All new employees with receive an initial home 1:1 visit with a supervising nurse, to ensure regulatory compliance in the future. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p> <p><b>Agency Response:</b> An mandatory all staff in service was held 3/11/2015 and included information and policy review and regulatory compliance for physician notification, assessing and addressing patient condition change, infection, patient/family complaint of pain, the need to fully assess wound care, including calf measurements, pedal and dorsal pulses and to promptly report changes, including infection issues to the physician. It is also expected that the staff fully address and educate patient/family regarding their concerns related to their care and the process of that care,</p>	03/11/2015

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G 175 Bldg. 00	<p>nurse (RN), perform wound care to patient #1 leg wounds #1 and #2, wounds were not cleansed with normal saline as ordered on the plan of care.</p> <p>B. Interview on 2/19/15 at 2:55 PM, the administrator, employee G, agreed that employee E, RN, did not perform wound care as ordered on the plan of care during home visit observation with patient #1.</p> <p>2. The agency's policy titled "Physician Participation in Plan of Care", dated April 2012, states, "The care will be provided in compliance with the therapeutic and diagnostic orders and accepted standards and practice."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review, interview, and policy review, the agency</p>	G 175	<p>monitoring patient response to treatment and the need for staff to notify the physicians of staff and patient/family changes in conditions. <b>Measures To Ensure Future Compliance:</b> In addition to in services related to the plan of correction the agency will utilize a compliance tool addressing each finding ,titled "State Compliance/Quality Assurance Monthly Audit Tool post Survey 2015", for 20% of patients quarterly <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p> <p><b>Agency Response:</b> Immediate response : the patients' chart will be updated and at next recert the</p>	03/11/2015

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	<p>failed to ensure the registered nurse included pertinent safety measure where noted on the plan of care (POC) for 2 of 11 records (#4 and #7) reviewed with the potential to affect all of the agency's patients.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Clinical record # 4, SOC 1/19/15, included a plan of care for the certification period 1/19/15 to 3/19/15 that failed to evidence safety measures for fall precautions.</li> <li>2. Clinical record #7, SOC 9/26/14, included a plan of care for the certification period 1/24/15 to 3/24/15 that failed to evidence safety measures for seizure precautions.</li> <li>3. On 2/20/15 at 2:35 PM, the administrator, employee G, agreed safety measures should be listed on the plan of care.</li> <li>4. Agency policy titled "Care Planning Process", dated April 2012, stated, "The clinical plan of care includes: ... H. Safety measures ... R. Other appropriate items such as precautions ... ."</li> </ol>		<p>485 will reflect the proper documentation in Locator box 15, for the appropriate safety and seizure precautions that have been and will continue to be in place</p> <p><b>Measures To Ensure Future Compliance: Measures To Ensure Future Compliance:</b></p> <p>In addition to in services related to the plan of correction on March 11, 2015, the Administrator will utilize compliance tool addressing each finding on the QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015" that includes patient safety issues. All current and new hires will receive information on falls and seizure precautions and be educated to document precautions in Locator box 15 in addition to documentation in the assessment. 20% of active patients will be audited quarterly</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	

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G 177  Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>Based on observation, interview, and review of policies and procedures, the agency failed to ensure the registered nurse addressed the patient's concern regarding his/her wounds to affect any patient cared for by Employee E, registered nurse, with the potential to affect all patients at the agency.</p> <p>Findings</p> <p>1. Home visit observation made on 2/16/15 at 3:10 PM to patient #1, with employee E, Registered Nurse (RN). The patient stated the right calf was hot to touch. Employee E, RN, did not address the patient's concern.</p> <p>2. Interview on 2/19/15 at 2:55 PM, the administrator, employee G, agreed that employee E, RN did not council/instruct the patient about the current status of the wound and address any concerns regarding the wound.</p>	G 177	<p><b>Agency Response:</b> An all staff inservice was held 3/11/2015 and included information and policy review and regulatory compliance for physician notification, assessing and addressing patient condition change, infection, patient/family complaint of pain, the need to fully assess wound care, including calf measurements, pedal and dorsal pulses and to promptly report changes, including infection issues to the physician. It is also expected that the staff fully address and educate patient/family regarding their concerns related to their care and the process of that care, monitoring patient response to treatment and the need for staff to notify the physicians of staff and patient/family changes in conditions. <b>Measures To Ensure Future Compliance:</b> In addition to in services related to the plan of correction the agency will utilize a compliance tool addressing each finding ,titled "State Compliance/Quality Assurance Monthly Audit Tool post Survey 2015", for 20% of patients quarterly <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and</p>	03/11/2015

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G 212  Bldg. 00	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.	G 212	ongoing  <b>Agency Response:</b> to this delinquency will be to competency test the two aides whose records were not complete to include bed baths and vital signs. <b>Measures To Ensure Future Compliance:</b> Accompanied with annual evaluations will be an aides competency checklist to be completed by the supervising nurse. This list will be completed for all new hires prior to completion of orientation. This issue will be discussed in the March 11, 2015 mandatory all staff meeting. In addition, it has been determined by the Administrator that annual 1:1 visits to include observation of direct patient care will be conducted with a supervising nurse. A qualified agency or individual will provide the initial competency for any newly hired Home Health aides or currently employed Home Health aides who did not meet the required competency guidelines during the 2 years the Agency is precluded from performing competencies. Following that 2 years a qualified nurse will perform the	03/20/2015

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G 215 Bldg. 00	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</p> <p>The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on interview and review of personnel files, the agency failed to ensure 1 of 1 home health aide files reviewed of aides ( F ) hired prior to 1/1/13 had completed the required number of inservices for 2013.</p> <p>Findings</p> <p>1. The personnel file for Employee F, date of hire 11/20/12, evidenced she attended a blood borne pathogen inservice in January 2013 and a vital signs inservice on 3/26/13. Each inservice had a completed test and packet of educational information.</p> <p>2. On 2/19/15 at 9:40 AM, the administrator indicated Employee F</p>	G 215	<p>competency testing for all home health aides that will include all the aforementioned areas of testing <b>Responsible person:</b> Administrator <b>Date complete:</b> 3.20.15 and ongoing</p> <p><b>Agency Response:</b> Provide education inservices to all aides that meet the mandated guidelines <b>Measures To Ensure Future Compliance:</b> . An annual in service calendar for the aides will be completed. The aides will be brought current on education and inservices in the 12 areas mandated. In the future, monthly in services will be provided to the aides, including a test to ensure knowledge of the subject matter. A copy will be kept in the a file with a sign in sheet, date and time of in service and qualified RN educator in charge of the in service. At least 8 of the annual 12 hours in service will include those that are mandated. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3.20.15 and ongoing</p>	03/20/2015

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G 242 Bldg. 00	<p>attended 3 hours of inservice in 2013 which was a combination of two hours for the blood borne pathogen inservice and 1 hour for the vitals signs inservice.</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program that included policy and administrative and clinical record review for 1 of 1 agency (See G 244); failed to ensure an evaluation of the agency's total program was conducted that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency creating the potential to affect all of the agency's 31 current patients (See G 245); failed to have an annual evaluation of the agency's total program that could be acted upon by those responsible for the operation of the agency (See G 246); failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record (See G 247); failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which they promote patient care that is</p>	G 242	<p><b>Agency Response:</b> This delinquency will be remedied at a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	03/20/2015

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G 244 Bldg. 00	<p>appropriate, adequate, effective, and efficient for 1 of 1 agency (See G 248); and failed to ensure mechanisms were in place for the collection of data for the annual evaluation for 1 of 1 agency (See G 249).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 284.52 Evaluation of the Agency's Program.</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. Based on administrative record and agency policy review and interview, the agency failed to have an annual evaluation of the agency's total program that included policy and administrative and clinical record review for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records</p>	G 244	<p><b>Agency Response:</b> This delinquency will be remedied at a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel</p>	03/31/2015

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	<p>failed to evidence an evaluation of the agency's total program that included policy and administrative and clinical record review.</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence the appropriateness, adequacy, effectiveness, and efficiency of the agency as outlined in the agency's policy.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and</p>		<p>qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015.</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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G 245 Bldg. 00	<p>the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. Based administrative record and policy review and interview, the agency failed to ensure an evaluation of the agency's total program was conducted that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency creating the potential to affect all of the agency's 31 current patients.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency.</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence the</p>	G 245	<p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The evaluation will include an analysis of the effectiveness of the organizational administrative</p>	03/20/2015

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G 246  Bldg. 00	<p>appropriateness, adequacy, effectiveness, and efficiency of the agency as outlined in the agency's policy.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. Based on administrative record and agency policy review and interview, the agency failed to have an annual</p>			G 246	<p>practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency, and the annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015. <b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p> <p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group</p>		03/20/2015

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	<p>evaluation of the agency's total program that could be acted upon by those responsible for the operation of the agency for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that could be acted upon by those responsible for the operation of the agency</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not the evaluation could be acted upon by those responsible for the operation of the agency.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational</p>		<p>meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency, and the annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015. <b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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G 247 Bldg. 00	<p>administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are maintained separately as administrative records. Based on administrative record and agency policy review and interview, the agency failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that was maintained as a separate administrative record.</li> <li>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the</li> </ol>	G 247	<p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs.</p> <p><b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015</p>	03/20/2015

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G 248  Bldg. 00	<p>agency and did not evidence the documentation was maintained as a separate administrative record.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Based on administrative record and</p>	G 248	<p>quarterly meetings to ensure compliance. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency, and the annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015. <b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p> <p><b>Agency Response:</b> At the March</p>	03/20/2015	

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	<p>agency policy review and interview, the agency failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence an evaluation of the agency's policies and administrative practices to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient.</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence policies and administrative practices had been evaluated to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The</p>		<p>2015 PAC meeting, the new policies that are updated throughout the year, will be reviewed for approval by the committee. They will be reviewed again in March 2016 to ensure regulatory compliance and that they meet the needs of the agency. The meeting <b>Measures To Ensure Future Compliance:</b> Annual review by the PAC committee with the next review date to be March 2016. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/20/2015 and ongoing</p>	

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G 249 Bldg. 00	<p>organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. Based on administrative record and agency policy review and interview, the agency failed to ensure mechanisms were in place for the collection of data for the annual evaluation for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence mechanisms were established in writing for the collection of</p>	G 249	<p><b>Agency Response:</b> This delinquency will be remedied with a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision,</p>	03/20/2015

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G 334	<p>pertinent data to assist in evaluation.</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence mechanisms were established in writing for the collection of pertinent data to assist in evaluation.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p>		<p>plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs and mechanisms for collection of data. <b>Measures To Ensure Future Compliance:</b> The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency . The annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review."</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> 3/20/2015 and ongoing</p>	

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Bldg. 00	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.	G 334	G334: (N540) Completion of the Comprehensive Assessment The agency failed to ensure that comprehensive assessments were completed within the 5 day requirement for 1 of 11 charts reviewed <b>Agency Response:</b> The agency will review and update their processes for recording and maintaining records of referral dates, patient hospital discharge dates, requested start of care dates by patient and physicians to more accurately reflect this guideline. <b>Measures To Ensure Future Compliance:</b> This issue was addressed in the March 11, 2015 all staff mandatory meeting. In addition, the Administrator will review all future assessments to ensure this requirement is met. The Administrator will utilize a QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015", for a minimum of 20% of active patients quarterly. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing	03/11/2015
G 339 Bldg. 00	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT			

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	<p>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> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the recertification comprehensive assessment data was consistent with other patient status data in the clinical record for 1 of 11 (#6) clinical records reviewed, with the potential to affect all patients.</p> <p>Findings</p> <p>1. Clinical record #6, start of care (SOC) 3/30/14, certification period 1/24/15 to 3/24/15 and a primary diagnosis of chronic skin ulcer:</p> <p>A. The recertification comprehensive assessment dated 3/20/15 states, " ... REASONS FOR RECERTIFICATION ... PT/INR, ... wound, ... needs continued monitoring of ____; ... significant lab findings ... continue wound care-patient/PCG unable to do wound care ... "</p>	G 339	<p><b>Agency Response:</b> This issue was addressed in the March 11, 2015 all staff mandatory meeting. Education will be provided to staff on proper completion of reassessments. In addition, the Administrator will review all future assessments to ensure this requirement is met. <b>Measures To Ensure Future Compliance:</b> The Administrator will utilize a QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015", for a minimum of 20% of active patients each quarter. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	03/11/2015

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	<p>B. Clinical record evidenced a recertification assessment completed on 1/20/15, by employee E, RN, that stated " ... (M1306) Does the patient have at least one unhealed pressure ulcer at stage II or higher ... No ... (M1322) Current number of stage I pressure ulcers ... 0 ... ."</p> <p>C. Clinical record evidenced on skilled nurse (SN) visit notes dated 2/17/15 and 2/11/15, completed by employee D, Licensed Practical Nurse(LPN), states, " ... 4. Provide wound care as ordered ... Not Applicable ... ." SN visit note dated 1/27/15, completed by employee D, LPN, states, " ... Patient Wounds ... Family applying SSD ... "</p> <p>2. Interview on 2/20/15 at 10:35 AM with administrator, employee G, the administrator stated that PT/INR's are not being done by agency and the patients family handles them and coordinates with the physician as stated in the recertification comprehensive assessment.</p> <p>3. Interview on 2/20/15 at 2:45 PM with administrator states that the family performs all wound care for patient. Administrator agrees no wound care has been provided by a SN from the agency as ordered in the POC and as stated in the</p>			

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N 000  Bldg. 00	<p>recertification comprehensive assessment.</p> <p>4. Interview on 2/20/15 at 2:45 PM, the administrator agrees the recertification comprehensive assessment is not consistent or accurate with other patient status data in the clinical record.</p> <p>5. Agency policy titled "Reassessments/Recertification", dated April 2012, states " ... 6. Documentation in the clinical record should support the assessment as well as the actions taken in response ... ."</p>	N 000		
	<p>This visit was for a home health state relicensure survey.</p> <p>Survey date: February 16 - 20, 2015</p> <p>Facility #: 008247</p> <p>Medicaid vendor #: 200839240</p> <p>Surveyor: Ingrid Miller, PHNS, RN Tameka Warren, PHNS, RN</p>			

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N 451 Bldg. 00	<p>Quality Review: Joyce Elder, MSN, BSN, RN March 3, 2015 and March 5, 2015</p> <p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p> <p>Based on agency document review, department document review, and interview, the agency failed to ensure a qualified person was functioning as the alternate administrator for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. A review of the agency documents failed to evidence the appointment of an alternate administrator after the resignation of Employee I, alternate administrator on 8/15/15.</li> <li>2. An agency document with a date of</li> </ol>	N 451	<p><b>Agency Response:</b> Immediate action was taken regarding this delinquency. The Department has been notified regarding the approval of the alternate administrator and necessary documents. The Agency has received approval <b>Measures To Ensure Future Compliance:</b> The agency will ensure that all required documents are completed and returned and will maintain ongoing communication with the Department when there are questions or concerns related to current status of submitted information. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	03/11/2015

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N 456 Bldg. 00	<p>11/25/14 evidenced Employee I had resigned on 8/15/14. This document was notification to the state about the alternate administrator resignation.</p> <p>3. On 2/19/15 at 12:05 PM, Employee G, administrator, indicated no one was authorized to be the alternate administrator.</p> <p>4. A review of Indiana State Department of Health documents evidenced no alternate administrator had been in place with the agency since August 15, 2014.</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to have an annual evaluation of the agency's total program that included policy and administrative review that monitored and evaluated the quality and appropriateness of care, resolved identified problems, and improved patient care for 1 of 1 agency.</p>	N 456	<b>Agency Response:</b> This delinquency will be remedied at a Professional Advisory Group meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a detailed agenda. The agenda will include, but not limited to the following: Overall policy review	03/20/2015

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	<p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency that monitored and evaluated the quality and appropriateness of care, resolved identified problems, and improved patient care .</li> <li>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence the appropriateness, adequacy, effectiveness, and efficiency of the agency as outlined in the agency's policy.</li> <li>3. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the</li> </ol>		<p>(annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs. <b>Measures To Ensure Future Compliance:</b> At the March 2015 PAC meeting, a calendar will be developed to set up all 2015 quarterly meetings to ensure compliance. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency, and the annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review. The next meetings will be as follows: June 2015, Sept 2015, Dec 2015. <b>Responsible person:</b> Administrator <b>Date complete:</b> March 2015 and ongoing</p>	

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N 458 Bldg. 00	<p>effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</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. (5) Annual performance evaluations.</p>	N 458	<b>Agency Response:</b> 100% of all current patient care employee personnel files will be reviewed for accuracy and compliance. Any deficiencies will be corrected,	03/20/2015

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N 462  Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred		brought current and documented in the records. <b>Measures To Ensure Future Compliance:</b> After completion of 100% audit of current patient care employee files , a audit tool will be utilized (or electronic tracking when available) for all new hires regarding mandatory requirements for personnel files. All direct care providers who are not current with their physical examinations (to include statement of communicable diseases), tuberculin skin testing/X-ray/screening tool (as applicable) will not be allowed to provide direct care until they are in compliance. All new hire folders will include the required medical information prior to direct patient care and reviewed and approved by the Administrator. The Administrator has developed a QA tool to assist with this process going forward and titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015"which will be utilized until the anticipated electronic personnel files and tracking are available. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3.20.15 and ongoing		

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	eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.	N 462	<b>Agency Response:</b> 100% of all current patient care employee personnel files will be reviewed for accuracy and compliance. Any deficiencies will be corrected, brought current and documented in the records. <b>Measures To Ensure Future Compliance:</b> After completion of 100% audit of current patient care employee files , a audit tool will be utilized (or electronic tracking when available) for all new hires regarding mandatory requirements for personnel files. All direct care providers who are not current with their physical examinations (to include statement of communicable diseases), tuberculin skin testing/X-ray/screening tool (as applicable) will not be allowed to provide direct care until they are in compliance. All new hire folders will include the required medical information prior to direct patient care and reviewed and approved by the Administrator. The Administrator has developed a QA tool to assist with this process going forward and titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015"which will be utilized until the anticipated electronic personnel files and tracking are	03/20/2015	

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NAME OF PROVIDER OR SUPPLIER  AT HOME QUALITY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 751 E PORTER AVENUE, SUITE 9 CHESTERTON, IN 46304
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N 464  Bldg. 00	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin</p>		<p>available. <b>Responsible person:</b> Administrator <b>Date</b> <b>complete:</b> 3.20.15 and ongoing</p>	

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	<p>test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p>	N 464	<p><b>Agency Response:</b> 100% of all current patient care employee personnel files will be reviewed for accuracy and compliance. Any deficiencies will be corrected, brought current and documented in the records. <b>Measures To Ensure Future Compliance:</b> After completion of 100% audit of current patient care employee files , a audit tool will be utilized (or electronic tracking when available) for all new hires regarding mandatory requirements for personnel files. All direct care providers who are not current with their physical examinations (to include statement of communicable diseases), tuberculin skin testing/X-ray/screening tool (as applicable) will not be allowed to provide direct care until they are in compliance. All new hire folders will include the required medical information prior to direct</p>	03/20/2015

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N 470  Bldg. 00	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.	N 470	patient care and reviewed and approved by the Administrator. The Administrator has developed a QA tool to assist with this process going forward and titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015"which will be utilized until the anticipated electronic personnel files and tracking are available. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3.20.15 and ongoing  <b>Agency Response:</b> A mandatory all staff in service was held 3/11/2015 to include information and policy review of agency's infection control policy for safe hand hygiene. The Administrator will initiate home health supervisory visits for all staff with an emphasis on infection control to include hand hygiene and the prevent the spread of infection. <b>Measures To Ensure Future Compliance:</b> <b>Responsible person:</b> Administrator will ensure that annual staff evaluations include home visits for patient care observation with a focus on issues of infection control. The current employee observation	03/20/2015	

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N 472 Bldg. 00	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on administrative record and agency policy review and interview, the agency failed to have an annual evaluation of the agency's total program that included policy and administrative review that monitored and evaluated the quality and appropriateness of care, resolved identified problems, and improved patient care for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records</p>	N 472	<p>form will be utilized in this process. Infection control findings and issues will be further discussed and presented at the all staff mandatory meeting on 3/11/2015. <b>Date complete:</b> 3.20.15 and ongoing <b>Responsible person:</b> Administrator</p> <p><b>Agency Response:</b> This delinquency will be remedied by development of a QA and performance improvement program that will audit active and discharged patient records on an ongoing basis, with a min record review of 20% quarterly. The data collected therein will be presented to Professional Advisory Group, meeting to be conducted in March 2015. The meeting will include the required attendees, including a physician. The meeting will include minutes and a sign in sheet as well as a</p>	03/20/2015

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	<p>failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency that monitored and evaluated the quality and appropriateness of care, resolved identified problems, and improved patient care .</p> <p>2. On 2/20/15 at 3:47 PM, the administrator, employee G, provided documents of an online Yearly Total Evaluation of the Agency, this assessment was not performed by the agency and did not evidence the appropriateness, adequacy, effectiveness, and efficiency of the agency as outlined in the agency's policy.</p> <p>3. The agency policy titled "Annual Organization Evaluation" with a revised date of April 2012 stated, "The organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures</p>		<p>detailed agenda. The agenda will include, but not limited to the following: Overall policy review (annually), medical supervision, plans of care, personnel qualifications (including review of State/Federal findings post survey), annual overall program evaluation to address efficiency, effectiveness, adequacy, appropriateness of the programs and mechanisms for collection of data. <b>Measures To Ensure Future Compliance:</b> The organization will appoint an authorized group or oversight committee to conduct ongoing quarterly chart audits, and annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency . The annual evaluation report will be submitted to the appropriate oversight committee and the governing body for review." <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/20/2015 and ongoing</p>	

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N 494 Bldg. 00	<p>based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p>	N 494	<p><b>Agency Response:</b>This deficiency was addressed at a mandatory all staff in service on 3/11/2015 and included the necessity to ensure all signed and dated (including Patient Rights) documents are in the patient's home folders prior to providing care at the initial home visit. They have been instructed to check patient home folders with each visit and re-educate patient and family on the importance of</p>	03/20/2015

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N 508 Bldg. 00	410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E)		maintaining all documents in the folder. In addition, the employee will receive disciplinary action for failure to ensure all documents are present in the patient's home folders. Immediate action will be taken to remedy this deficiency. The information will be provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts fail to contain the information. Education of staff was completed 3.11.15 Patient Home folders will be brought current and complete by 3.20.15 <b>Measures To Ensure Future Compliance:</b> The Administrator has developed a checklist titled "State Compliance/Quality Assurance Monthly Audit Tool " that includes a review of all newly created home admission packets. Immediate action will include a 100% review of all home folders conducted by the nursing staff to ensure current compliance, and a 20% review each quarter thereafter. The expectation is for all nursing staff will check the folders for completion at each visit to maintain compliance. Failure to do so may result in disciplinary action, up to and including termination of employment. <b>Person Responsible:</b> Administrator	

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	<p>(b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:</p> <p>(2) The patient has the right to the following:</p> <p>(E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p>	N 508	<p><b>Agency Response:</b>This deficiency was addressed at a mandatory all staff in service on 3/11/2015 and included the necessity to ensure all signed and dated (including Patient Rights) documents are in the patient's home folders prior to providing care at the initial home visit. They have been instructed to check patient home folders with each visit and re-educate patient and family on the importance of maintaining all documents in the folder. In addition, the employee will receive disciplinary action for failure to ensure all documents are present in the patient's home folders. Immediate action will be taken to remedy this deficiency. The information will be provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts fail to contain the information. Education of staff was completed 3.11.15 Patient Home folders will be brought current and complete by 3.20.15 <b>Measures To Ensure Future Compliance:</b> The</p>	03/20/2015

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N 518  Bldg. 00	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.	N 518	Administrator has developed a checklist titled "State Compliance/Quality Assurance Monthly Audit Tool " that includes a review of all newly created home admission packets. Immediate action will include a 100% review of all home folders conducted by the nursing staff to ensure current compliance, and a 20% review each quarter there after. The expectation is for all nursing staff will check the folders for completion at each visit to maintain compliance. Failure to do so may result in disciplinary action, up to and including termination of employment. <b>Person Responsible:</b> Administrator  <b>Agency Response:</b> This deficiency was addressed at a mandatory all staff in service on 3/11/2015 and included the necessity to ensure all signed and dated (including Patient Rights) documents are in the patient's home folders prior to providing	03/20/2015	

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			<p>care at the initial home visit. They have been instructed to check patient home folders with each visit and re-educate patient and family on the importance of maintaining all documents in the folder. In addition, the employee will receive disciplinary action for failure to ensure all documents are present in the patient's home folders. Immediate action will be taken to remedy this deficiency. The information will be provided as detailed and explained fully at time of admission as well as provided/explained to all current patients whose charts fail to contain the information. Education of staff was completed 3.11.15 Patient Home folders will be brought current and complete by 3.20.15 <b>Measures To Ensure Future Compliance:</b> The Administrator has developed a checklist titled "State Compliance/Quality Assurance Monthly Audit Tool " that includes a review of all newly created home admission packets. Immediate action will include a 100% review of all home folders conducted by the nursing staff to ensure current compliance, and a 20% review each quarter there after. The expectation is for all nursing staff will check the folders for completion at each visit to maintain compliance. Failure to do so may result in disciplinary action, up to and including termination of employment. <b>Person Responsible:</b></p>	

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N 524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(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>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure the plan of care (POC) covered all pertinent diagnosis and durable medical equipment for 6 of 8 record reviewed with the potential to affect all the agency's current patients.</p> <p>Findings</p>	N 524	<p>Administrator</p> <p><b>Agency Response:</b> The records will be updated for 4 patients whose plan failed to include all necessary DME's, accurate orders and pertinent diagnoses. <b>Measures To Ensure Future Compliance:</b> All staff inservice on 3/11/2015 includes expectation to include all DME's, accurate wound orders and pertinent diagnoses on assessment for incorporation into the POC. In addition, the</p>	03/20/2015

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	<p>1. Home Visit observation on 2/16/15 at 3:10 AM to patient #1 noted durable medical equipment (DME) supplies present in the home included wound care supplies.</p> <p>Clinical record of patient # 1, Start of Care (SOC) 2/5/15, the plan of care (POC) for the certification period 2/5/15 to 4/5/15 failed to include wound care DME supplies.</p> <p>2. Home Visit observation on 2/17/15 at 9:10 AM to patient #3 noted documentation regarding Chronic Kidney Disease, stage 3 and DME supplies present in the home were shower seat and pulse oximeter.</p> <p>A. Interview with patient #3 on 2/17/15 at 9:40 AM, patient stated being treated for stage 3 Chronic Kidney Disease and agency is aware of the diagnosis.</p> <p>B. Clinical record of patient # 3, included a plan of care for the certification period 1/28/15 to 3/28/15 that failed to list Chronic Kidney Disease, stage 3 as a diagnosis and failed to include DME supplies.</p> <p>C. The administrator, employee G, on 2/19/15 at 3:50 PM, agreed that Chronic Kidney Disease, stage 3, should have</p>		<p>Administrator will utilize a QA tool that addresses compliance with DME's, pertinent diagnoses, accurate orders on POC's and will add necessary DME's, orders and diagnoses to the out of compliance POC's. Future compliance will be addressed using QA tool for all new patient's. Tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015", for 20% of patients quarterly.</p> <p><b>Responsible person:</b> Administrator Completed : 3.20.15 and ongoing</p>	

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	<p>been listed on the POC as a diagnosis and DME supplies should have been listed on the POC.</p> <p>3. Home visit observation on 2/17/15 at 11:00 AM to patient #4, noted DME present in the patient's home that included a shower chair, safety toilet seat, walker and rolling seated walker.</p> <p>Clinical record of patient # 4, SOC 1/19/15, included a plan of care for the certification period 1/19/15 to 3/19/15 that failed to include shower chair, safety toilet seat, walker and rolling seated walker.</p> <p>4. Home Visit observation on 2/18/15 at 10:10 AM to patient #5 noted DME supplies present in the home included hospital bed, pressure relieving mattress, wheelchair, wound vac, and wound care supplies.</p> <p>Clinical record of patient # 5, SOC 12/11/14, included a plan of care for the certification periods 12/11/14 to 2/8/15 and 2/9/15 to 4/9/15 that failed to include the DME supplies of hospital bed, pressure relieving mattress, wheelchair, wound vac, and wound care supplies.</p> <p>5. Clinical record of patient # 6, SOC 3/30/14, included a plan of care for the</p>			

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	<p>certification period 1/24/15 to 3/24/15 that stated, "Skilled Nursing: ... Provide wound care as ordered ... ." The POC failed to list exact wound care orders from physician and the family performs all wound care.</p> <p>6. Clinical record of patient # 8, SOC 12/15/14, included a plan of care for the certification period 12/15/14 to 2/12/15 that failed to evidence the patient ambulates with walker and walker is present in home during staff assessments. The POC failed to include this DME.</p> <p>7. The agency policy titled "Initial and Comprehensive Assessment", dated April 2012, stated, "Purpose: To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of care ... 3. ... all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented ... L. Equipment presently in the home and potentially needed by the patient ... ."</p> <p>8. Agency policy titled "Care Planning Process", dated April 2012, stated "The clinical plan of care includes: ... L. Supplies and equipment required ... ."</p> <p>9. During interview with Nursing Supervisor on 2/19/15 at 4:10 PM, the</p>			

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NAME OF PROVIDER OR SUPPLIER  AT HOME QUALITY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 751 E PORTER AVENUE, SUITE 9 CHESTERTON, IN 46304
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N 527 Bldg. 00	<p>Nursing Supervisor indicated the plans of care failed to include all medical equipment in patient's homes as required by policy.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review, interview, and review of policy and procedures, the agency failed to ensure notified the physician of changes in condition in 3 of 11 clinical records review with patient #1, #5, #6, creating the potential to affect any patients cared for by employee E, Registered Nurse (RN), employee B, Physical Therapist (PT) and employee G, Administrator RN, with the potential to affect all patients receiving services from the agency.</p> <p>Findings:</p> <p>Patient #1's clinical record, start of care (SOC) 2/5/15, certification period 2/5/15-4/5/15, failed to show the physician was notified of a pain level of 8, from employee B, PT, to inform the physician of signs and symptoms of</p>	N 527	<p><b>Agency Response:</b> Immediate action was taken at time of survey to ensure patients identified received appropriate care and physicians were aware of the change in condition. An all staff inservice was held 3/11/2015, as well as 1:1 counseling with identified clinical staff, to include information and policy review and regulatory compliance for physician notification, assessing and addressing patient condition change, infection, patient/family complaint of pain, the need to fully assess wound care, including calf measurements, pedal and dorsal pulses and to promptly report changes, including infection issues to the physician. It is also expected that the staff fully address and educate patient/family regarding their concerns related to their care and the process of that care, monitoring patient response to treatment and the need for staff</p>	03/11/2015

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	<p>infection present to right calf and pain level of 8 during PT Evaluation on 2/10/15.</p> <p>A. The record failed to show the physician was notified of changes in condition, from employee E, RN, to inform the physician of signs and symptoms of infection present to right calf and pain level of 10. Observation at home visit on 2/16/15 at 3:20 PM of patient #1 with employee E, RN, noted signs and symptoms of infection to right calf and patient expressed a pain level of 10.</p> <p>B. Interview on 2/19/15 at 2:50 PM, the administrator, employee G, agreed that employee E, RN should have notified the physician of changes in the patient's condition.</p> <p>C. Interview on 2/19/15 at 3:10 PM, employee E, RN agreed the physician should have been notified of changes in the patient's condition.</p> <p>2. Clinical record #5, SOC 12/11/14, certification periods 12/11/14 to 2/8/15 and 2/9/15 to 4/9/15 included a clinical visit note dated 2/18/15 by employee D, licensed practical nurse (LPN), shows notification to supervisor, administrator, employee G, informing of signs and</p>		<p>to notify the physicians of staff and patient/family changes in conditions. <b>Measures To Ensure Future Compliance:</b> In addition to ongoing in services related to the plan of correction, the Administrator will utilize a compliance tool addressing each finding on the QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015" for 20% of all active patients quarterly <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	

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	<p>symptoms of infection present to both toe wounds. Clinical record failed to evidence, employee G, administrator, notified physician of signs and symptoms of infection to toe wounds. Observation during home visit on 2/18/15 at 10:00 AM of patient #5 with employee D, LPN, identified signs and symptoms of infection of wounds to right great toe and left second toe noted by LPN.</p> <p>On 2/19/15 at 11:50 AM, the administrator, employee G, agreed the physician should have been notified of changes in the patient's condition regarding SN visit on 2/16/15 at 10:00 AM.</p> <p>3. Clinical record #6, SOC 3/30/14, certification period 1/24/15 to 3/24/15, failed to evidence the physician was notified by employee G, administrator, after being informed of a skilled nurse SN visit note dated 2/3/15 where the LPN, employee D, noted "One fluid-filled blister to B. [both] feet near 5th toes. Band-aids to both."</p> <p>On 2/20/15 at 2:50 PM, the administrator, employee G, indicated the physician was not notified of the blisters because the family did not want the nurse to call a certain physician, who was not listed on the plan of care. When asked,</p>			

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	<p>why the physician listed on the plan of care was not notified, the administrator stated that physician was a cardiologist and not the primary physician. When asked why the primary physician was not listed on the plan of care, the administrator shrugged.</p> <p>4. The agency's policy titled "Ongoing Assessments" dated April 2012 states, "... During each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit thereafter ... C. Pain status when applicable ... B. Changes in patient condition ... ."</p> <p>5. The agency's policy titled "Monitoring Patient's Response/ Reporting to Physician" dated April 2012 states, "... Purpose : To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician ... A. Significant changes to the patient's condition ... F. When there is a problem implementing the plan of care ... ."</p> <p>6. The agency's policy titled "Wound Management" dated 5/1/02 states, "... 6. All assessment information will be documented and significant changes (e.g., fever, signs/symptoms of infection, increase in wound area or bleeding) will</p>			

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N 532 Bldg. 00	<p>be communicated to the treated physician ... "</p> <p>7. The agency's policy titled "Care Planning Process" dated April 2012 states, " ... 10. Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ... "</p> <p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record review, interview, and review of policy and procedures, the agency failed to ensure notified the physician of changes in condition in 3 of 11 clinical records review with patient #1, #5, #6, creating the potential to affect any patients cared for by employee E, Registered Nurse (RN), employee B, Physical Therapist (PT) and employee G, Administrator RN, with the potential to affect all patients receiving services from the agency.</p>	N 532	<p><b>Agency Response:</b> Immediate action was taken at time of survey to ensure patients identified received appropriate care and physicians were aware of the change in condition. A all staff inservice was held 3/11/2015 to include information and policy review and regulatory compliance for physician notification, assessing and addressing patient condition change, infection, patient/family complaint of pain, the need to fully assess wound care, including calf measurements, pedal and dorsal pulses and to promptly report</p>	03/11/2015

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	<p><b>Findings:</b></p> <p>Patient #1's clinical record, start of care (SOC) 2/5/15, certification period 2/5/15-4/5/15, failed to show the physician was notified of a pain level of 8, from employee B, PT, to inform the physician of signs and symptoms of infection present to right calf and pain level of 8 during PT Evaluation on 2/10/15.</p> <p>A. The record failed to show the physician was notified of changes in condition, from employee E, RN, to inform the physician of signs and symptoms of infection present to right calf and pain level of 10. Observation at home visit on 2/16/15 at 3:20 PM of patient #1 with employee E, RN, noted signs and symptoms of infection to right calf and patient expressed a pain level of 10.</p> <p>B. Interview on 2/19/15 at 2:50 PM, the administrator, employee G, agreed that employee E, RN should have notified the physician of changes in the patient's condition.</p> <p>C. Interview on 2/19/15 at 3:10 PM, employee E, RN agreed the physician should have been notified of changes in the patient's condition.</p>		<p>changes, including infection issues to the physician. It is also expected that the staff fully address and educate patient/family regarding their concerns related to their care and the process of that care, monitoring patient response to treatment and the need for staff to notify the physicians of staff and patient/family changes in conditions. <b>Measures To Ensure Future Compliance:</b> In addition to ongoing in services related to the plan of correction, the Administrator will utilize a compliance tool addressing each finding on the QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015" for 20% of all active patients quarterly <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	

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	<p>2. Clinical record #5, SOC 12/11/14, certification periods 12/11/14 to 2/8/15 and 2/9/15 to 4/9/15 included a clinical visit note dated 2/18/15 by employee D, licensed practical nurse (LPN), shows notification to supervisor, administrator, employee G, informing of signs and symptoms of infection present to both toe wounds. Clinical record failed to evidence, employee G, administrator, notified physician of signs and symptoms of infection to toe wounds. Observation during home visit on 2/18/15 at 10:00 AM of patient #5 with employee D, LPN, identified signs and symptoms of infection of wounds to right great toe and left second toe noted by LPN.</p> <p>On 2/19/15 at 11:50 AM, the administrator, employee G, agreed the physician should have been notified of changes in the patient's condition regarding SN visit on 2/16/15 at 10:00 AM.</p> <p>3. Clinical record #6, SOC 3/30/14, certification period 1/24/15 to 3/24/15, failed to evidence the physician was notified by employee G, administrator, after being informed of a skilled nurse SN visit note dated 2/3/15 where the LPN, employee D, noted "One fluid-filled blister to B. [both] feet near</p>			

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	<p>5th toes. Band-aids to both."</p> <p>On 2/20/15 at 2:50 PM, the administrator, employee G, indicated the physician was not notified of the blisters because the family did not want the nurse to call a certain physician, who was not listed on the plan of care. When asked, why the physician listed on the plan of care was not notified, the administrator stated that physician was a cardiologist and not the primary physician. When asked why the primary physician was not listed on the plan of care, the administrator shrugged.</p> <p>4. The agency's policy titled "Ongoing Assessments" dated April 2012 states, "... During each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit thereafter ... C. Pain status when applicable ... B. Changes in patient condition ... ."</p> <p>5. The agency's policy titled "Monitoring Patient's Response/ Reporting to Physician" dated April 2012 states, "... Purpose : To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician ... A. Significant changes to the patient's condition ... F. When there is a problem implementing the plan of care ...</p>			

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N 537 Bldg. 00	<p>6. The agency's policy titled "Wound Management" dated 5/1/02 states, " ... 6. All assessment information will be documented and significant changes (e.g., fever, signs/symptoms of infection, increase in wound area or bleeding) will be communicated to the treated physician ... "</p> <p>7. The agency's policy titled "Care Planning Process" dated April 2012 states, " ... 10. Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ... " "</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on observation, interview, and review of procedures, the agency failed to ensure the registered nurse, employee E, provided care in accordance with the plan of care in home visit observation with patient #1 completed creating the potential to affect any patient cared for by Employee E, registered nurse.</p> <p>Findings</p>	N 537	<p><b>Agency Response:</b> Employee E failed to follow MD orders for 3 patients. This employee will receive counsel and 1:1 education. Failure to comply in the future may result in further disciplinary action. <b>Measures To Ensure Future Compliance:</b> The administrator will monitor notes for compliance with MD orders. An inservice was held on 3/11/2015 that included</p>	03/11/2015

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N 540 Bldg. 00	<p>1. Home visit observation made on 2/16/15 at 3:10 PM to patient #1, with employee E, Registered Nurse.</p> <p>A. Observed employee E, registered nurse (RN), perform wound care to patient #1 leg wounds #1 and #2, wounds were not cleansed with normal saline as ordered on the plan of care.</p> <p>B. Interview on 2/19/15 at 2:55 PM, the administrator, employee G, agreed that employee E, RN, did not perform wound care as ordered on the plan of care during home visit observation with patient #1.</p> <p>2. The agency's policy titled "Physician Participation in Plan of Care", dated April 2012, states, "The care will be provided in compliance with the therapeutic and diagnostic orders and accepted standards and practice."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record review, home</p>	N 540	<p>education on the necessity and requirements to follow physician orders or contact physician for issues that may indicate a need to alter the plan of care. In addition, the Administrator will conduct 1:1 home visits with all employees to ensure compliance to regulatory standards of care. The Administrator will utilize agency form titled, "Observation". All new employees with receive an initial home 1:1 visit with a supervising nurse, to ensure regulatory compliance in the future. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p> <p><b>Agency Response:</b> The agency will review and update their</p>	03/11/2015

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N 543  Bldg. 00	<p>visit observation, policy review and interview, the agency failed to ensure the registered nurse completed the initial assessment visit for 1 of 11 records (#10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, start of care 10/27/14, evidenced an initial / comprehensive assessment completed by the Registered Nurse on 10/27/14 that was not complete. The weight had not been completed at this visit.</p> <p>A. On 2/19/15 at 4:00 PM, the administrator stated, when asked if weights should be completed at the initial / comprehensive assessment, "Normally, yes."</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse included pertinent safety measure where noted on the plan of care (POC) for 2 of 11 records (#4 and #7) reviewed with the</p>	N 543	<p>processes for recording and maintaining records of referral dates, patient hospital discharge dates, requested start of care dates by patient and physicians to more accurately reflect this guideline. <b>Measures To Ensure Future Compliance:</b> This issue was addressed in the March 11, 2015 all staff mandatory meeting. In addition, the Administrator will review all current and future assessments to ensure this require is met. The Administrator will utilize a QA tool titled, "State Compliance/Quality Assurance Audit Tool 20% Review post Survey 2015", for a minimum of 20% of active patients quarterly. <b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p> <p><b>Agency Response:</b> Immediate response : the patients' chart will be updated and at next recert the 485 will reflect the proper documentation in Locator box 15, for the appropriate safety and seizure precautions that have</p>	03/11/2015	

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N 586  Bldg. 00	<p>potential to affect all of the agencies patients.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Clinical record # 4, SOC 1/19/15, included a plan of care for the certification period 1/19/15 to 3/19/15 that failed to evidence safety measures for fall precautions.</li> <li>2. Clinical record #7, SOC 9/26/14, included a plan of care for the certification period 1/24/15 to 3/24/15 that failed to evidence safety measures for seizure precautions.</li> <li>3. On 2/20/15 at 2:35 PM, the administrator, employee G, agreed safety measures should be listed on the plan of care.</li> <li>4. Agency policy titled "Care Planning Process", dated April 2012, stated, "The clinical plan of care includes: ... H. Safety measures ... R. Other appropriate items such as precautions ... ."</li> </ol> <p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of</p>		<p>been and will continue to be in place. Staff was trained and educated on this issue at inservice held March 11,2015</p> <p><b>Measures To Ensure Future Compliance: Measures To Ensure Future Compliance:</b> In addition to in services related to the plan of correction on March 11, 2015, the Administrator will utilize compliance tool addressing each finding on the QA tool titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015" that includes patient safety issues. All current and new hires will receive information on falls and seizure precautions and be educated to document precautions in Locator box 15 in addition to documentation in the assessment. 20% of active patients will be audited quarterly</p> <p><b>Responsible person:</b> Administrator <b>Date complete:</b> 3/11/2015 and ongoing</p>	

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NAME OF PROVIDER OR SUPPLIER  AT HOME QUALITY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 751 E PORTER AVENUE, SUITE 9 CHESTERTON, IN 46304
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	<p>eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath.</p> <p>(B) Bath; sponge, tub or shower.</p> <p>(C) Shampoo, sink, tub, or bed.</p> <p>(D) Nail and skin care.</p> <p>(E) Oral hygiene.</p> <p>(F) Toileting and elimination.</p> <p>(10) Safe transfer techniques and ambulation.</p> <p>(11) Normal range of motion and positioning.</p> <p>(12) Adequate nutrition and fluid intake.</p> <p>(13) Medication assistance.</p>			

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N 596 Bldg. 00	<p>(14) Any other task that the home health agency may choose to have the home health aide perform.</p> <p>Based on interview and review of personnel files, the agency failed to ensure 1 of 1 home health aide files reviewed of aides ( F ) hired prior to 1/1/13 had completed the required number of inservices for 2013.</p> <p>Findings</p> <p>1. The personnel file for Employee F, date of hire 11/20/12, evidenced she attended a blood borne pathogen inservice in January 2013 and a vital signs inservice on 3/26/13. Each inservice had a completed test and packet of educational information.</p> <p>2. On 2/19/15 at 9:40 AM, the administrator indicated Employee F attended 3 hours of inservice in 2013 which was a combination of two hours for the blood borne pathogen inservice and 1 hour for the vitals signs inservice.</p> <p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows:</p>	N 586	<p><b>Agency Response:</b> to this delinquency testing of two aides whose records were not complete, be completed by a qualified agency or individual, and to include bed baths and vital signs. <b>Measures To Ensure Future Compliance:</b> Accompanied with annual evaluations will be an aides competency checklist to be completed by a qualified agency or supervising nurse. This list will be completed for all new hires prior to completion of orientation. This issue was discussed in the March 11, 2015 mandatory all staff meeting. In addition, it has been determined by the Administrator that annual 1:1 visits to include observation of direct patient care will be conducted with a qualifying contracted agency / individual or supervising nurse <b>Responsible person: Administrator Date complete: 3.20.15 and ongoing</b></p>	03/20/2015

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	(1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and	N 596	<b>Agency Response:</b> 100% of all current patient care employee personnel files will be reviewed for accuracy and compliance. Any deficiencies will be corrected, brought current and documented in the records. <b>Measures To Ensure Future Compliance:</b> After completion of 100% audit of current patient care employee files , a audit tool will be utilized (or electronic tracking when available) for all new hires regarding mandatory requirements for personnel files. All direct care providers who are not current with their physical examinations (to include statement of communicable diseases), tuberculin skin testing/X-ray/screening tool (as applicable) will not be allowed to provide direct care until they are in compliance. All new hire folders will include the required medical information prior to direct patient care and reviewed and approved by the Administrator. The Administrator has developed a QA tool to assist with this process going forward and titled, "State Compliance/Quality Assurance Audit Tool post Survey 2015"which will be utilized until the anticipated electronic personnel files and tracking are available. <b>Responsible person:</b>	03/20/2015

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