

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157609	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  ACTIVE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2146 45TH ST HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0000	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 7/16/12 - 7/19/12</p> <p>Facility #: 6656</p> <p>Medicare #: 157609</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Skilled unduplicated census: 54 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">July 24, 2012</p>	G0000			

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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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review, home visit observation, and interview, the agency failed to ensure the skilled nurse (Employee E ) followed standards regarding infection control in 1 of 3 home visits observed with a skilled nurse with the potential to affect all of the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>On 7/18/12 at 9:30 AM, Employee E, Registered Nurse, was observed, with gloved hand, to pull out the lancet out of a needle stick device that did not have a safety feature built in to automatically eject the needle.</li> <li>On 7/19/12 at 10:30 AM, Employee A, the administrator, indicated the pulling out of the lancet out of the needle stick device put Employee E at risk of contamination with a bloodborne pathogen.</li> <li>The agency policy titled "Standard</li> </ol>	G0121	<p>G121 The Administrator and management conducted a mandatory inservice on 7/27/12 to reeducate the staff on proper infection control procedures and the importance of compliance (see attachments # 1a and 1b). Particular attention was placed upon proper handling of needles, lancets, and other sharp instruments or devices used in procedures. In addition, the Agency has purchased posi-grip forceps to be used in the removal of lancets from the needle stick devices. The staff will be educated on the proper usage procedure of these devices during the inservice as well. Furthermore, each staff nurse performing blood sugar tests for a patient will be observed performing the blood sugar test procedures and lancet removal by the Director of Nursing no later than 8/10/12 to ensure that each nurse is following the appropriate techniques. See attachment # 2. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	08/10/2012

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	Precautions / Universal Precautions" with an approval date of 6/4/12 stated, "Prevention of Accidental Injuries ... take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices used during procedures. Do not manually resheath, recap, contaminated needles. Do not bend, cut, or clip needles. Do not use two handed resheathing technique."			

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included a timely physician signature and verbal order by the registered nurse for 2 of 10 records reviewed (Clinical records #3 and #9).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC), included a plan of care for the certification period of 6/9/12 - 8/7/12 that failed to evidence a verbal order signed by the registered nurse or a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 6/9/12 - 8/7/12 did not have a signed verbal order by a registered nurse or a physician signature</p>	G0159	G159 The Agency adopted a new tracking database on 7/27/12 to track all verbal and written physician orders and all plans of care. The database includes information on the type of order or plan of care. The database includes information on the type of order or plan of care, the physician it was sent to, the date the order was sent for signature, the effective date of the order, whether the order or plan of care was received back with a signature, and the date that it was received with a signature. The Office Manager will monitor the status of all orders and plans of care for timeliness on a weekly basis. Any verbal orders more than 14 days old, written orders older than 25 days old, or plans of care more than 25 days old which are not signed will be referred to the Director of Nursing of Administrator for immediate follow up. Any such orders or plans of care will be hand delivered to the physician's office	07/27/2012			

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	<p>with the date.</p> <p>b. On 7/16/12 at 4:30 PM, the administrator indicated the above clinical document lacked a signed verbal order and a physician signature with the date.</p> <p>2. Clinical record #9, SOC 11/19/1, included a plan of care for the certification period of 5/17/12 - 7/15/12 that failed to evidence a verbal order signed by the nurse or timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 5/17/12 - 7/15/12 lacked a signed verbal order by the registered nurse and / or physician signature and date.</p> <p>b. On 7/16/12 at 3:30 PM, the administrator indicated no signatures by the registered nurse or physician were present at time of record review.</p> <p>3. The policy titled "Recertification Period" with a review date of 6/4/12 stated, "A recertification form is written every 60 days during the patient's existing coverage period. The form is completed by a member of the professional home health staff and must be signed by a RN</p>		<p>for signature. See attachment # 3. The Agency has also hired several new staff members in the last two months to improve the flow of documents to improve the timeliness of signatures by registered nurses and physicians. The staff has been educated on the new practices of the Agency and the importance of compliance in a mandatory inservice held on 7/27/12. See attachment # 1a. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>within 48 hours. Once completed, the forms are either mailed or hand carried to the physician for his/her signature. A copy of the form is kept in the patient's chart until the signed copy is attained."</p> <p>4. The policy titled "Conformance with Physician's Orders" with an approval date of 6/4/12 stated, "Verbal and / or telephone orders may be received by a licensed nurse only and are to be immediately recorded and signed. The physician's signature must be obtained within 30 days ... All orders are to be written ... The doctor must sign the verbal order within 14 days and date accordingly."</p>			

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G0229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 1 of 4 records reviewed (Clinical record #10) of patients receiving home health and skilled services with the potential to affect all the patients of the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. Clinical record #10, start of care 8/1/11, included a plan of care for the certification period 1/29/12 - 3/27/12 with orders for skilled nurse and home health aide services. The record failed to evidence documentation of supervisory visits of the home health aide until 3/12/12.</li> <li>2. On 7/19/12 at 5:05 PM, the administrator indicated the registered nurse had failed to complete the supervisory visits as required by policy.</li> <li>3. The agency policy titled "Performance Evaluation: Title of position: Community Health Registered Nurse" with a review</li> </ol>	G0229	<p>G229 A mandatory inservice was held on 7/27/12 in which the staff was educated on the Agency policy titled "Performance Evaluation: Title of Position: Community Health Registered Nurse" in regards to the supervision of Home Health Aides at a minimum frequency of once every 14 days. The importance of compliance was also stressed. See attachments # 1a and 4. In addition, Skilled Nurse visit notes will be audited each week to ensure that a registered nurse has performed the supervisory visits as required. See attachment # 5. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/27/2012			

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	date of 6/4/12 stated, "Supervises and evaluates the care given by the Home Health aide as needed, and at a minimum of once every 14 days for skilled cases."			

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G0236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure clinical records were appropriately authenticated per agency policy for 2 of 10 records reviewed (Clinical record #3 and #7) with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 2/10/12, evidenced dates on several documents had been altered. This was evidenced by the following:</p> <p>a. The clinical record document titled "Beneficiary Signed statement" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below.</p>	G0236	G236 All Starts of Care will be audited when received by the office to ensure accuracy of dates and to monitor for evidence of date alteration. All erroneous dates or other data shall be corrected as described in the Agency policy entitled "Chart – General Information" (see attachment #6). In addition, a mandatory inservice was held on 7/27/12 to educate the staff on proper timeframes to begin care on new referrals. The Agency policy titled "Chart – General Information" will also be discussed, with an emphasis on how to correct errors appropriately (See attachment # 1a). Additionally, 80% of charts will be audited on a quarterly basis to ensure errors are corrected in accordance with Agency policy and that no signs of inappropriate alterations are evident (see attachments # 7 & 8). Furthermore, Employee K's employment was terminated on 4/30/12. The Administrator will	07/27/2012			

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	<p>b. The clinical record document titled "Patient Authorization Form" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below. This document stated, "Patient name and date 2/10/12."</p> <p>c. The clinical record document titled "Patient Agreement signatures" with a date of 2/10/12 and signature of patient #3 and Employee K, Registered Nurse, evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>d. The clinical record document titled "Privacy Act statement - Health care records" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>e. The clinical record document titled "Letter of confirmation for notification of changes of services and charges" with a date of 2/10/12 and signature of patient #3 and Employee K evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>f. The clinical record document titled "Admission Packet Contents" with an date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below. The document stated,</p>		<p>be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>"Referral sheet, welcome greetings, agency brochure, beneficiary signed statement, patient agreement signature, patient bill of rights and responsibilities."</p> <p>g. On 7/16/12 at 4:30 PM, the administrator indicated the dates had been altered.</p> <p>2. Clinical record #7, SOC 11/11/11 evidenced dates on several documents had been altered. This was evidenced by the following:</p> <p>a. In the patient's home record, a document titled "Admission Packet Contents" included Patient #7's signature and date of 11/10/11. This document was a checklist of all the items to be signed at the start of care. This included Referral sheet, welcome greetings, Statement of patient's privacy rights, and patient bill of rights and responsibilities.</p> <p>b. In the patient's clinical record kept at the agency, a document titled "Admission Packet Contents" included Patient #7's signature and date of 11/11/2011. This document was a checklist of all the items to be signed at the start of care. This included Referral sheet, welcome greetings, Statement of patient's privacy rights, and patient bill of rights and responsibilities. This</p>			

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	<p>document had been altered from the original 11/10/2011 to 11/11/2011 with the fourth "1" altered from a "0."</p> <p>c. The clinical record document titled "Beneficiary Signed statement" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>d. The clinical record document titled "Patient Authorization Form" with a date of 11/10/11 and signature of patient #3 evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>e. The clinical record document titled "Patient Agreement Signatures" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>f. The clinical record document titled "Statement of Patient's Financial Liability" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>g. The clinical record document titled "Patient Rights and Responsibilities" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p>				

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	<p>h. On 7/19/12 the administrator indicated the clinical record documents had been altered.</p> <p>3. The agency policy titled "Chart - General information" with an approval date of 6-4-12 stated, "Purpose 1. To keep an accurate record of the patient's condition ... to provide a permanent record ... General instructions 1. The chart is a legal and confidential document ... The nurse is responsible for the completeness and accuracy of the record ... Ink eradicators are not to be used. To correct a minor error, draw one line through the mistake and write error and sign name. To correct a lengthy error, recopy the sheet, sign name at the bottom of the old sheet, draw an 'X' across the old page and place the new sheet directly in front of the old one."</p>			

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review, home visit observation, and interview, the agency failed to ensure the skilled nurse (Employee E ) followed agency policies regarding infection control in 1 of 3 home visits observed with a skilled nurse with the potential to affect all of the patients of the agency.</p> <p>Findings</p> <p>1. On 7/18/12 at 9:30 AM, Employee E, Registered Nurse, was observed, with gloved hand, to pull out the lancet out of a needle stick device that did not have a safety feature built in to automatically eject the needle.</p> <p>2. On 7/19/12 at 10:30 AM, Employee A, the administrator, indicated the pulling out of the lancet out of the needle stick device put Employee E at risk of contamination with a bloodborne pathogen.</p> <p>3. The agency policy titled "Standard</p>	N0470	<p>N0470 The Administrator and management conducted a mandatory inservice on 7/27/12 to reeducate the staff on proper infection control procedures and the importance of compliance (see attachments # 1a and 1b). Particular attention was placed upon proper handling of needles, lancets, and other sharp instruments or devices used in procedures. In addition, the Agency has purchased posi-grip forceps to be used in the removal of lancets from the needle stick devices. The staff will be educated on the proper usage procedure of these devices during the inservice as well. Furthermore, each staff nurse performing blood sugar tests for a patient will be observed performing the blood sugar test procedures and lancet removal by the Director of Nursing no later than 8/10/12 to ensure that each nurse is following the appropriate techniques. See attachment # 2. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	08/10/2012

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	<p>Precautions / Universal Precautions" with an approval date of 6/4/12 stated, "Prevention of Accidental Injuries ... take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices used during procedures. Do not manually resheath, recap, contaminated needles. Do not bend, cut, or clip needles. Do not use two handed resheathing technique."</p>			

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N0524	<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> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included a timely physician signature and verbal order by the registered nurse for 2 of 10 records reviewed (Clinical records #3 and #9).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC), included a plan of care for the</p>	N0524	N0524 The Agency adopted a new tracking database on 7/27/12 to track all verbal and written physician orders and all plans of care. The database includes information on the type of order or plan of care. The database includes information on the type of order or plan of care, the physician it was sent to, the date the order was sent for signature, the effective date of the order, whether the order or plan of care was received back with a signature, and the date that it was	07/27/2012			

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	<p>certification period of 6/9/12 - 8/7/12 that failed to evidence a verbal order signed by the registered nurse or a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 6/9/12 - 8/7/12 did not have a signed verbal order by a registered nurse or a physician signature with the date.</p> <p>b. On 7/16/12 at 4:30 PM, the administrator indicated the above clinical document lacked a signed verbal order and a physician signature with the date.</p> <p>2. Clinical record #9, SOC 11/19/1, included a plan of care for the certification period of 5/17/12 - 7/15/12 that failed to evidence a verbal order signed by the nurse or timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 5/17/12 - 7/15/12 lacked a signed verbal order by the registered nurse and / or physician signature and date.</p> <p>b. On 7/16/12 at 3:30 PM, the</p>		<p>received with a signature. The Office Manager will monitor the status of all orders and plans of care for timeliness on a weekly basis. Any verbal orders more than 14 days old, written orders older than 25 days old, or plans of care more than 25 days old which are not signed will be referred to the Director of Nursing of Administrator for immediate follow up. Any such orders or plans of care will be hand delivered to the physician's office for signature. See attachment # 3. The Agency has also hired several new staff members in the last two months to improve the flow of documents to improve the timeliness of signatures by registered nurses and physicians. The staff has been educated on the new practices of the Agency and the importance of compliance in a mandatory inservice held on 7/27/12. See attachment # 1a. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>administrator indicated no signatures by the registered nurse or physician were present at time of record review.</p> <p>3. The policy titled "Recertification Period" with a review date of 6/4/12 stated, "A recertification form is written every 60 days during the patient's existing coverage period. The form is completed by a member of the professional home health staff and must be signed by a RN within 48 hours. Once completed, the forms are either mailed or hand carried to the physician for his/her signature. A copy of the form is kept in the patient's chart until the signed copy is attained."</p> <p>4. The policy titled "Conformance with Physician's Orders" with an approval date of 6/4/12 stated, "Verbal and / or telephone orders may be received by a licensed nurse only and are to be immediately recorded and signed. The physician's signature must be obtained within 30 days ... All orders are to be written ... The doctor must sign the verbal order within 14 days and date accordingly."</p>			

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 1 of 4 records reviewed (Clinical record #10) of patients receiving home health and skilled services with the potential to affect all the patients of the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. Clinical record #10, start of care 8/1/11, included a plan of care for the certification period 1/29/12 - 3/27/12 with orders for skilled nurse and home health aide services. The record failed to evidence documentation of supervisory visits of the home health aide until 3/12/12.</li> <li>2. On 7/19/12 at 5:05 PM, the administrator indicated the registered nurse had failed to complete the supervisory visits as required by policy.</li> </ol>	N0606	<p>N0606 A mandatory inservice was held on 7/27/12 in which the staff was educated on the Agency policy titled "Performance Evaluation: Title of Position: Community Health Registered Nurse" in regards to the supervision of Home Health Aides at a minimum frequency of once every 14 days. The importance of compliance was also stressed. See attachments # 1a and 4. In addition, Skilled Nurse visit notes will be audited each week to ensure that a registered nurse has performed the supervisory visits as required. See attachment # 5. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/27/2012			

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	3. The agency policy titled "Performance Evaluation: Title of position: Community Health Registered Nurse" with a review date of 6/4/12 stated, "Supervises and evaluates the care given by the Home Health aide as needed, and at a minimum of once every 14 days for skilled cases."				

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N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure clinical records were appropriately authenticated per agency policy for 2 of 10 records reviewed (Clinical record #3 and #7) with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 2/10/12, evidenced dates on several documents had been altered. This was evidenced by the following:</p>	N0608	N0608 All Starts of Care will be audited when received by the office to ensure accuracy of dates and to monitor for evidence of date alteration. All erroneous dates or other data shall be corrected as described in the Agency policy entitled "Chart – General Information" (see attachment #6). In addition, a mandatory inservice was held on 7/27/12 to educate the staff on proper timeframes to begin care on new referrals. The Agency policy titled "Chart – General Information" will also be discussed, with an emphasis on how to correct errors appropriately (See attachment # 1a). Additionally, 80% of charts	07/27/2012			

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	<p>a. The clinical record document titled "Beneficiary Signed statement" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>b. The clinical record document titled "Patient Authorization Form" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below. This document stated, "Patient name and date 2/10/12."</p> <p>c. The clinical record document titled "Patient Agreement signatures" with a date of 2/10/12 and signature of patient #3 and Employee K, Registered Nurse, evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>d. The clinical record document titled "Privacy Act statement - Health care records" with a date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below.</p> <p>e. The clinical record document titled "Letter of confirmation for notification of changes of services and charges" with a date of 2/10/12 and signature of patient #3 and Employee K evidenced the "0" in "2/10/12" had a "2" written below.</p>		<p>will be audited on a quarterly basis to ensure errors are corrected in accordance with Agency policy and that no signs of inappropriate alterations are evident (see attachments # 7 &amp; 8). Furthermore, Employee K's employment was terminated on 4/30/12. The Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>f. The clinical record document titled "Admission Packet Contents" with an date of 2/10/12 and signature of patient #3 evidenced the "0" in "2/10/12" had a "2" written below. The document stated, "Referral sheet, welcome greetings, agency brochure, beneficiary signed statement, patient agreement signature, patient bill of rights and responsibilities."</p> <p>g. On 7/16/12 at 4:30 PM, the administrator indicated the dates had been altered.</p> <p>2. Clinical record #7, SOC 11/11/11 evidenced dates on several documents had been altered. This was evidenced by the following:</p> <p>a. In the patient's home record, a document titled "Admission Packet Contents" included Patient #7's signature and date of 11/10/11. This document was a checklist of all the items to be signed at the start of care. This included Referral sheet, welcome greetings, Statement of patient's privacy rights, and patient bill of rights and responsibilities.</p> <p>b. In the patient's clinical record kept at the agency, a document titled "Admission Packet Contents" included Patient #7's signature and date of</p>						

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	<p>11/11/2011. This document was a checklist of all the items to be signed at the start of care. This included Referral sheet, welcome greetings, Statement of patient's privacy rights, and patient bill of rights and responsibilities. This document had been altered from the original 11/10/2011 to 11/11/2011 with the fourth "1" altered from a "0."</p> <p>c. The clinical record document titled "Beneficiary Signed statement" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>d. The clinical record document titled "Patient Authorization Form" with a date of 11/10/11 and signature of patient #3 evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>e. The clinical record document titled "Patient Agreement Signatures" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>f. The clinical record document titled "Statement of Patient's Financial Liability" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p>						

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	<p>g. The clinical record document titled "Patient Rights and Responsibilities" with a date of 11/10/11 and signature of patient #3 and Employee K evidenced the "0" in "11/10/11" had a "1" written below.</p> <p>h. On 7/19/12 the administrator indicated the clinical record documents had been altered.</p> <p>3. The agency policy titled "Chart - General information" with an approval date of 6-4-12 stated, "Purpose 1. To keep an accurate record of the patient's condition ... to provide a permanent record ... General instructions 1. The chart is a legal and confidential document ... The nurse is responsible for the completeness and accuracy of the record ... Ink eradicators are not to be used. To correct a minor error, draw one line through the mistake and write error and sign name. To correct a lengthy error, recopy the sheet, sign name at the bottom of the old sheet, draw an 'X' across the old page and place the new sheet directly in front of the old one."</p>			