

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157583	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
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NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOME HEALTH OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 LAKE AVE STE 150 FORT WAYNE, IN 46805
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G0000	<p>This was a Home Health Federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: July 31- August 3, 2012.</p> <p>Facility #: 011110</p> <p>Medicaid #: 200841710B</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census: 44</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">August 8, 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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G0107	<p><b>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</b></p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on document review and interview, the agency failed to ensure the resolution of complaints within the time frame allotted per agency policy for 1 of 1 agency with the potential to affect all the agency's patients who complain.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>During document review on 7/31/12, two Complaint / Concern Reports were noted in the agency complaint book as not completed. One was dated and recorded on 6/28/12, one was dated and recorded on 6/29/12. Both complaint forms failed to evidence the complaint / concerns were "Referred to" anyone in the agency, and both failed to evidence any "Action Taken" and "Follow-up/Resolution."</li> <li>On 8/1/12 at 10:35 AM, employee S indicated the agency's policy for complaints is to bring resolution and document that resolution within 30 days.</li> </ol>	G0107	<p><b>G 107 – 484.10(b)(5) Exercise of Patient Rights – Failure to ensure the resolution of complaints within the time frame allotted per agency policy .</b></p> <p><b>Corrective Action:</b> All agency personnel were instructed on 8/9/12:</p> <p>To ensure appropriate action will be taken to address all complaints, the following sections of the Amedisys Home Health Administration Manual, <u>RI-009 Patient/Caregiver Grievance/Complaint</u> policy were reviewed with all agency personnel on 08/06/12:</p> <ol style="list-style-type: none"> <li><i>The agency is to initiate a complaint investigation within 10 business days of the agency's receipt of the complaint and document all components of the investigation.</i></li> <li><i>Documentation of the complaint is completed by the employee to whom the complaint is received and forwarded to the agency that includes the</i></li> </ol>	09/01/2012	

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	3. On 8/1/12 at 3:00 PM, employee S indicated the complaints from 6/28 and 6/29 were being handled by employee D who works out of two states and two of the complaints did have resolution but just weren't documented yet on the forms.		<p><i>following:</i></p> <p>3. <i>Date of complaint</i></p> <p>4. <i>Person filing report</i></p> <p>5. <i>Person involved in complaint</i></p> <p>6. <i>Person lodging complaint</i></p> <p>7. <i>Nature of complaint(s)</i></p> <p>8. <i>Actions taken by agency's Director of Operations/designee</i></p> <p>9. <i>Response of person involved in complaint</i></p> <p>10. <i>The investigation and documentation must be completed within 30 calendar days after the agency receives the complaint, unless the agency has and documents reasonable cause for delay.</i></p> <p>11. <i>The Director of Operations, or designee, is responsible for reviewing every complaint; determining the necessity of corrective action; and communication regarding the resolution with the client, patient, caregiver, family member, consumer no later than 30 calendar days following the receipt of complaint; as well as documenting all activities involved with the complaint, investigation, analysis, resolution and communication.</i></p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. The Director of Operations is responsible to review each complaint to ensure policy is followed, and documented within</p>		

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			<p>the 30 day time limit.</p> <p>2. In the event there is a reasonable cause for delay of the resolution process, the Director of Operations is responsible to ensure evidence of, and documentation for, the delay is present.</p> <p><b>Completion Date:</b> Compliance with policy will be at 100% by September 1, 2012, and continue at 100% on an on-going basis.</p>	

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G0121	<p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> 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 home visit observation, policy review, and interview, the agency failed to ensure the employees followed infection control guidelines for 2 of 5 home visits and failed to follow their policy regarding home health aide care plans in 1 of 1 home visit with a home health aide with the potential to affect all the agency's patients. (#2, 5)</p> <p>Findings include:</p> <p>1. During home visit observation with patient #2 on 8/1/12 at 12:25 PM, employee M was observed obtaining a blood pressure with a manual cuff / sphygmomanometer. Upon finishing the task, employee M put the blood pressure cuff back into its case and into the equipment bag without cleaning the cuff.</p> <p>A. During interview on 8/1/12 at 1:10 PM, employee M indicated they clean the blood pressure cuff at home in the evening.</p> <p>B. During interview on 8/1/12 at 1:50 PM, employee S indicated the policy</p>	G0121	<p><b>G121 – 484.12(c) Compliance with Accepted Professional Standards – Part One: Failure to ensure the employees followed infection control guidelines; Part Two: Failure to follow policy regarding home health aide care plans, specifically a copy of the home health aide care plan is provided to the home health aide and the patient.</b></p> <p><b>Corrective Action, Part One:</b> All agency personnel were instructed by 8/9/12: To ensure compliance with Accepted Professional Standards for Infection Control and Prevention, the following Amedisys policies were reviewed with all agency personnel on or before August 9, 2012, by the Director of Operations during live training sessions:</p> <p>1) Infection Prevention Manual, Chapter 5 – Patient Care Polices: a) PCP-001: Hand Hygiene – specifically to the use of gloves, and triggers to change gloves during provision of patient care. b) PCP-003: Decontamination of Reusable Equipment –</p>	08/17/2012
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	<p>states the cleaning of reusable equipment is to be done after each patient use.</p> <p>2. During home visit observation with patient #5 on 8/2/12 at 12:00 PM, employee G, a Home Health Aide (HHA), was observed assisting the patient with a shower and then shaving the patient. During the shower, the HHA washed the patient's back and buttocks, assisted the patient to dry off and dress, and then preceded to shave the patient without changing the gloves in between tasks.</p> <p>A. On 8/2/12 at 1:45 PM, employee S indicated the HHA should have changed gloves after the shower.</p> <p>B. The admission folder in the patient's home failed to evidence a copy of the Home Health Aide Care Plan.</p> <p>During interview on 8/2/12 at 12:10 PM, employee G indicated the Aide Care Plan was in the folder during the last visit and confirmed it was not there now.</p> <p>3. The agency's policy titled "Hand Hygiene," #PCP-001, revised 05/2011 states, "Guidelines: The need for hand washing or cleaning with an alcohol based "waterless hand cleanser" depends on the type, intensity, duration and sequence of activities. The Center for</p>		<p>specifically to protocol for cleaning the equipment used to assess patient vital signs and electronic medical record tools used in the patient home.</p> <p>2) All clinicians and para-professionals demonstrated competency by simulated or return demonstration for the infection prevention measures reviewed as above.</p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. The Director of Operations, or a supervising clinical designee, will perform at least one un-announced home visit with each clinician or para-professional staff member to validate 100% adherence to infection prevention practices by September 3, 2012.</p> <p>2. The Director of Operations will perform a minimum of two (2) home visits with clinicians and para-professional staff members at least quarterly to validate on-going compliance.</p> <p>3. The Business Office Manager, or designee, will monitor shelf to bag stock requisitions to ensure all clinicians and paraprofessionals are ordering/receiving appropriate quantities of infection prevention/decontamination supplies.</p> <p><b>Completion Date:</b> Compliance will be validated at 100% by</p>				

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	<p>Disease Control (CDC) recommends routinely washing hands in the following situations: 7. (*) Decontaminate hands if moving from a contaminated-body site during patient care. 15. Change gloves during patient care if moving from a contaminated body site to a clean body site."</p> <p>4. The agency's policy titled "Decontamination of Re-usable Equipment," #PCP-003, revised 05/2011, states, "Procedure: 1. Non-critical items should be cleaned in between patient use with (i.e., blood pressure cuffs, pulse oximeters, stethoscopes, tourniquets, flashlights and scales etc.) will be cleaned with 70% isopropyl alcohol or an agency approved wipe after each patient use."</p> <p>5. The agency's policy titled "Home Health Aide Care Plan / Assignment," #AA-011, revised 07/2012 states under section titled "Procedure: A copy is provided to the Home Health Aide and patient."</p>		<p>September 3, 2012, and continue at 100% on an on-going basis.</p> <p><b>Corrective Action, Part Two:</b> All agency personnel were instructed on 8/9/12: To ensure compliance with policy regarding home health aide care plans, specifically that a copy of the home health aide care plan is provided to the home health aide and the patient, the following processes and responsibilities have been reviewed with all office and field staff:</p> <ol style="list-style-type: none"> <li>1. The Business Office Manager, or designee, is responsible to upload/data enter each Home Health Aide Care Plan into CellTrak, the electronic medical record system used for Home Health Aide services. When entered, the original Home Health Aide Care Plan will be initialed and dated in the bottom right hand corner to indicate the plan has been entered into the Celltrak system.</li> <li>2. Each Home Health Aide will verify they have access to the current Home Health Aide Care Plan prior to making visits for all assigned patients, or will contact the supervising RN for a verbal review of the Care Plan prior to providing and/or assisting with any personal care/grooming activities when access to the Home Health Aide Care Plan is not available.</li> <li>3. The BOM/scheduler will verify there is a current/updated</li> </ol>		

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			<p>HHA Care Plan in the medical record prior to scheduling visits for the Home Health Aide.</p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <ol style="list-style-type: none"> <li>1. Business Office Manager will review all SOC, ROC, RC packets turned in by admitting/assessing clinicians and verify: <ol style="list-style-type: none"> <li>a. the yellow copy of the HHA Care Plan was left in the home,</li> <li>b. the pink copy was given to the HHA and</li> <li>c. the original was entered and filed in the chart</li> </ol> </li> <li>2. Each Home Health Aide and visiting clinician will review the patient's home folder to ensure the yellow copy of the Home Health Aide Care Plan is present and current on each visit to their assigned patients receiving Home Health Aide services, and report missing documents to the supervising RN.</li> <li>3. Supervising RN will take immediate steps to ensure the patient is provided with another copy of the Home Health Aide Plan to include: <ol style="list-style-type: none"> <li>a. Making a photocopy of the original/most current from the medical record</li> <li>b. Placing the photocopy in the mailbox of the next staff member scheduled to visit the patient, with request to document delivery of copy in their visit record</li> </ol> </li> <li>4. All medical records have</li> </ol>		

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			<p>been audited by the Business Office Manager to verify the presence of Home Health Aide Care Plans for all patients receiving Home Health Aide Services</p> <p>5. All Home Health Aides have access to CellTrac and have verified their access to the Care Plans of each assigned patient with the Business Office Manager</p> <p>6. All home folders have been audited by supervising RN or field clinicians to verify the presence of Home Health Aide Care Plans for patients receiving Home Health Aide services</p>		

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G0159	<p><b>484.18(a) PLAN OF CARE</b> 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, home visit observation, policy review, and interview, the agency failed to ensure the Plan of Care included all Durable Medical Equipment (DME) used by patients for 2 of 5 home visit observations with the potential to affect all the agency's patients. (# 3, 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit observation with patient #3 on 8/2/12 at 10:10 AM, DME observed in the home included wheel chair, toilet riser, hemi-walker, and quad cane. The Plan of Care (POC) dated 6/14-8/12/12 failed to list these DME.</li> <li>2. During home visit observation with patient #5 on 8/2/12 at 12:00 PM, DME observed in the home included rollator walker, grab bar by bath tub, and shower bench. The POC dated 6/26-8/24/12</li> </ol>	G0159	<p><b>G 159 – 484.18(a) Plan of Care – Failure to ensure the Plan of Care included all Durable Medical Equipment (DME) used by patients.</b></p> <p><b>Corrective Action:</b> All agency personnel were instructed on 8/9/12:</p> <ol style="list-style-type: none"> <li>1. Billable and non-billable supplies provided to the patient by agency personnel, and durable medical equipment used by the patient in the home will be included on the 485/Plan of Care in the section identified as <i>Locator 14. Durable Medical Equipment and Supplies.</i></li> <li>2. Policy <u>AA-014, Plan of Care/Care Planning Process</u>, revised 5/2011, was reviewed with particular attention to identifying the types of DME and supplies the patient uses and/or requires for home use.</li> </ol> <p>Rehab Clinicians responsible for Therapy Only Comprehensive Assessments/Reassessments</p>	08/17/2012			

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	<p>failed to list these DME.</p> <p>3. The agency's policy titled "Plan of Care (POC)/Care Planning Process," #AA-014, revised 05/2011, states, "484.18(a) Standard: Plan of Care: the plan of care developed in consultation with the agency staff cover all pertinent diagnoses, including mental status, types of services and equipment required. ... 3. Documentation of the Care Planning Process includes, but is not limited to the following information: CMS 485 (POC)."</p> <p>4. On 8/2/12 at 1:45 PM, employee S agreed the DME should be listed on the POC.</p>		<p>and development of the Plan of Care received additional training regarding identification of, and steps to ensure inclusion of DME and Supplies in the 485/Plan of Care.</p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. The Director of Operations will review all 485/Plan of Care documents for compliance before certifying.</p> <p>2. The Business Office Manager will review all 485/Plan of Care documents for compliance before sending to the physician for signature.</p> <p><b>Completion Date:</b> 100% Compliance achieved 8/17/12, and will continue on an on-going basis.</p>		

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G0166	<p><b>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</b> Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse obtained verbal orders from the physician for new medications and the agency's policies were congruent with federal regulations for 2 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#1 and 3)</p> <p>Findings include:</p> <p>1. During home visit observation on 8/1/12 at 8:45 AM, employee F was observed talking with patient #1 about taking Tylenol and Miralax. The patient indicated to employee F that they take both Tylenol and Miralax "every now and then." The Visit Note dated 7/16/12 indicated the Licensed Practical Nurse (LPN) "obtained an order for Tylenol for pain and pt [patient] has been using it some over the week-end and stated it does help." Under the section titled "Medications" the skilled nurse (SN) failed to indicate the start/change date as</p>	G0166	<p><b>G 166 – 484.18(c) Conformance with Physician Orders – Failure to ensure the registered nurse obtained verbal orders from the physician for new medications.</b></p> <p><b>Corrective Action:</b> All agency personnel were instructed on 8/9/12:</p> <ol style="list-style-type: none"> <li>1. A physician order is required for all services, medications and treatments</li> <li>2. Medications include, but are not limited to, prescriptions, over-the-counter, herbal, homeopathic, etc.</li> <li>3. All verbal physician orders will be put in written format as soon as possible after receipt, the same day as received.</li> <li>4. All verbal physician orders received by the LPN will be validated and co-signed by the RN prior to implementation.</li> <li>5. Medication orders must be clearly communicated to all members of the team when a change occurs.</li> </ol> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and</p>	08/23/2012			

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	<p>prompted by the documentation. The record failed to evidence the Medication Profile was updated with the "Tylenol 500 mg 1 po (per mouth) q [every] 4-6 hours" order. The record failed to evidence the SN communicated with the Case Manager who fills the patient's medication box to notify of the new Tylenol order. The record failed to evidence an order was written and obtained from the physician for the Tylenol.</p> <p>The Visit Note dated 7/25/12 indicated the patient told employee F they are concerned about the bowels not moving as well as they thought they should be and that the patient has Miralax from the hospital. The Visit Note indicated employee F told the patient how to use it either daily or every other day to see if the patient felt better. Under the section titled "Medication" employee F indicated "no change since last visit" and the document failed to evidence the physician was notified and/or orders were obtained for the Miralax. The document failed to evidence further attempts to obtain an order for Miralax.</p> <p>2. Clinical record #3, start of care 6/14/12, contained a Skilled Nurse Visit Note dated 6/18/12 which indicated a "Medication change since last visit" of Cipro 250 mg by mouth twice daily:</p>		<p>on-going.</p> <ol style="list-style-type: none"> <li>All verbal physician orders will be written, signed and dated the receiving the clinician the same day the order is received, transmitted electronically the agency, and reviewed by the Director of Operations.</li> <li>All changes to medication orders will be communicated to all members of the team, and communication regarding the changes will be documented in the communication/coordination of care section of the visit record by the clinician receiving the order, or via a clinical note addendum the same day the change occurs.</li> <li>The Director of Operations will review all verbal physician orders obtained by the LPN to ensure compliance with validation and counter-signature by the RN requirements.</li> </ol> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>		

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	<p>began 6.15.12 and "Orders obtained." The record failed to evidence the orders were obtained.</p> <p>3. The agency's policy titled "Medication Administration," #MA-001, revised 02/2012, states, "B. Medication Order Guidelines: 1. Whenever possible, the practitioner should request that a written medication administration order be sent to the home health agency. 2. Medication orders received must be written, signed and dated by the licensed prescriber. Order must be obtained as soon as possible. 5. It is imperative that medication orders be clearly communicated with all members of the health care team. *Note: The clinician should contact the physician or prescriber by any means at their disposal to determine or verify the components and intent of the medication order before administration of the medication. The physician/prescriber should be called or paged or the order faxed to the physician for clarification. Verification of the order is considered a priority and all attempts to verify must be documented in the medical record. C. Telephone Orders: 3. The following protocol will be used in taking verbal or telephone orders for medication. The practitioner receiving the verbal order will: a. Write the order or enter it into the computer immediately;."</p>			

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	<p>4. The agency's policy titled "Services Provided/Supervision of Disciplines-RN/LPN," #AA-007(a), revised 05/2012, states, "III. Licensed Practical Nurse (LPN/LVN) ... Verbal physician orders received by the LPN/LVN will be validated and co-signed by the RN prior to implementation."</p> <p>6. At 9:15 AM on 8/1/12, employee F indicated they still need to update the medication profile concerning the Tylenol and Miralax as they missed updating it on the days the patient informed them of those medications.</p>			

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G0169	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services by or under the supervision of a registered nurse.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Licensed Practical Nurse (LPN) was supervised by a Registered Nurse (RN) at least every 30 days for 1 of 3 patients who received LPN services for longer than 30 days. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #3 contained a Plan of Care with a Start of Care date 6/23/12. The record indicated the LPN began Skilled Nurse (SN) visits on 6/29/12. The record failed to evidence a supervisory visit of the LPN was completed as of 8/1/12.</li> <li>On 8/1/12 at 2:35 PM, employee S indicated the supervisory visit was not documented in the computer as having been completed by 30 days.</li> <li>The agency's policy titled "Services Provided/Supervision of Disciplines-RN/LPN," #AA-007(a), revised 05/2012, states, "The Registered Nurse must supervise the LPN/LVN every 30 days, unless the state requirements are more stringent, which includes a visit to</li> </ol>	G0169	<p><b>G 169 – 484.30 Skilled Nursing Services – Failure to ensure the Licensed Practical Nurse (LPN) was supervised by a Registered Nurse (RN) at least every 30 days.</b></p> <p><b>Corrective Action:</b> All Agency Personnel were instructed on 8/9/12:</p> <ol style="list-style-type: none"> <li>Clinical and office staff members were instructed and received written material addressing the mandatory requirement for LPN supervision visits to be conducted every 30 days.</li> <li>Supervisory visits will be coded and documented per policy on the visit record documented by the supervising clinician.</li> </ol> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <ol style="list-style-type: none"> <li>Daily - Business Office Manager is responsible to monitor scheduled visits for supervision of the LPN, verify supervisory visits occurred and were documented timely, and report deviations to the Director of Operation as soon as identified.</li> <li>Weekly - The Director of Operations will review supervisory visit reports to ensure 100% compliance.</li> </ol>	08/23/2012
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	the patient home and the LPN/LVN may or may not be present."		<b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.	

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G0224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on home visit observation, interview, and policy review, the agency failed to ensure the Registered Nurse (RN) assigned only tasks the Aide is allowed to perform per policy for 1 of 1 home visit with HHA services with the potential to affect all the agency's patients who receive HHA services. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #5 contained a Home Health Aide Care Plan dated 6/26/12. Under the section titled Personal Care, the RN assigned Nail care to be done every visit.</li> <li>2. The agency's policy titled "Home Health Aide Care Plan/Assignment," #AA-011, revised 07/2012 states, "Procedure: ... 9. Tasks that will NOT be delegated to the Home Health Aide: Clipping and filing nails."</li> </ol>	G0224	<p><b>G 224 – 484.36(c)(1) Assignment &amp; Duties of Home Health Aide – Failure to ensure the Registered Nurse (RN) assigned only tasks the Aide is allowed to perform per policy, specifically Nail Care.</b></p> <p><b>Corrective Action:</b> All agency personnel were instructed on 8/9/12:</p> <ol style="list-style-type: none"> <li>1. The Home Health Aide provides personal care and grooming activities as assigned by the RN</li> <li>2. The RN assigns only tasks the Aide is allowed to perform</li> <li>3. The Aide immediately contacts the Supervising RN/Therapist when assigned tasks are identified that are not on the approved task/allowed skill list per policy.</li> <li>4. Policy #AA-011, <u>Home Health Aide Care Plan/Assignment</u>, revised 7/2012, was reviewed with all supervising clinicians and Home Health Aides to ensure the tasks allowed and not allowed for the Aide to perform were clearly understood by all parties.</li> </ol>	08/23/2012

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			<p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. The Director of Operations is responsible to review all new/changed/updated Home Health Aide Care Plans for compliance with appropriate/approved Home Health Aide task assignment.</p> <p>2. The Business Office Manager is responsible to review all Home Health Aide Care Plans uploaded to CellTrac for appropriate/approved Home Health Aide task assignment.</p> <p>3. The Supervising RN is responsible to review all Home Health Aide Care Plans during supervisory visits to ensure only tasks the Aide is allowed to perform are assigned.</p> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>		

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G0226	<p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the Home Health Aide (HHA) was providing care as ordered on the Aide Care Plan for 2 of 2 clinical records reviewed of patients receiving HHA services with the potential to affect all the agency's patients who receive HHA services. (#5, 6)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a Home Health Aide Care Plan dated 6/26/12. Under the section titled Personal Care, the following tasks are ordered to be done every visit: Oral care, Hair care, Shampoo, Shave, Skin care, Nail care, and Assist with dressing.</p> <p>a. The Home Health Aide Progress Notes dated 7/30, 7/27, 7/24, 7/20, and 7/16, failed to evidence the Aide completed Oral care and Nail care.</p> <p>b. The Home Health Aide Progress</p>	G0226	<p><b>G 226 – 484.36(c)(2) Assignment &amp; Duties of Home Health Aide – Failure to ensure the Home Health Aide (HHA) was providing care as ordered on the Aide Care Plan, specifically Hair Care, Nail Care, Oral Care, Shampoo, Shave, Skin Care, or Assist with Dressing. Corrective Action:</b> 1. The Home Health Aide provides personal care and grooming activities as assigned by the RN 2. The RN assigns only tasks the Aide is allowed to perform 3. The Aide immediately contacts the Supervising RN/Therapist when assigned tasks are not completed and reports the reason the task(s) could not be completed as ordered. 4. Policy <u>#AA-011, Home Health Aide Care Plan/Assignment</u>, revised 7/2012, was reviewed with all supervising clinicians and Home Health Aides to ensure mandatory compliance requirements are clearly understood by all parties. <b>Monitoring Process:</b> Until 100% compliance achieved, and</p>	08/23/2012			

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	<p>Notes dated 7/13 and 7/6 failed to evidence the Aide completed Nail care.</p> <p>c. The Home Health Aide Progress Note dated 7/9 failed to evidence the Aide completed Shave and Nail care.</p> <p>2. Clinical record #6 contained a Home Health Aide Care Plan dated 6/20/12. Under the section titled Personal Care, the following tasks are ordered to be done every visit: Oral care, Hair care, Shampoo, Shave, and Skin care.</p> <p>a. The Home Health Aide Progress Notes dated 7/23, 7/20, and 7/16 failed to evidence the Aide completed Oral care and Shave.</p> <p>b. The Home Health Aide Progress Notes dated 7/11, 7/9, and 7/6 failed to evidence the Aide completed Shave.</p> <p>3. The agency's policy titled "Home Health Aide Care Plan/Assignment," #AA-011, revised 07/2012 states, "Procedure: ... 3. The Home Health Aide is responsible for performing the duties as assigned and for notifying the agency regarding any patient problems, needs, or concerns. ... 9. Tasks that will NOT be delegated to the Home Health Aide: Clipping and filing nails."</p>		<p>on-going. <b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going</p>		

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	4. On 8/2/12 at 1:55 PM, employee S indicated understanding of the HHA not following the care plan as written by the Registered Nurse.			

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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 corrections made in the clinical record were made according to agency policy for 1 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 contained a Clinician Admit Sheet dated 7/17/12 with a Requested Start of Care (SOC) date of 7/18/12. During home visit observation with patient #4 on 8/2/12 at 10:40 AM, the admission documents in the patient's folder indicated the patient signed the documents on 7/19/12. The Plan of Care (POC) indicated a SOC date of 7/26/12; however, the patient did not know why the services were not started on 7/19 as signed.</p>	G0236	<p><b>G 236 – 484.48 Clinical Records – Failure to ensure corrections made in the clinical record were made according to policy, specifically a single line through the error, noted as error and initialed with date, to be followed with documentation of the correct information immediately above or following the error.</b></p> <p><b>Corrective Action:</b> All agency personnel received verbal instruction and written material addressing the appropriate procedure per policy for corrections made in the clinical record. Reference: Policy <u>#IM-008(c) Clinical Record, Late Entry and Corrections</u>, revised 2/2012, states: "Documentation errors made in the clinical record may be corrected by drawing a single line through the word(s) [error], initialing and dating the correction and documenting the change."</p>	08/23/2012			

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	<p>a. On 8/2/12, at 2:00 PM, clinical record #4 was reviewed, and the original Patient Acknowledgement and Consents document in the paper portion of the clinical record indicated the 26th was written over the originally signed 19th of the documents.</p> <p>b. The Patient Acknowledgement and Consents paperwork scanned into the computer system were noted as being signed on 7/26/12.</p> <p>c. The record failed to evidence the physician was notified of a later SOC date.</p> <p>d. The Clinician Admit Sheet dated 7/17/2012 contains three corrections to the document each with a line through the information needing to be corrected, but failed to evidence date and initials.</p> <p>e. The dates of patient and employee signatures were not properly indicated as corrections per policy on the following documents: the Patient Acknowledgements and Consents form page 3, Universal Precautions and Patient's Rights, Patient Emergency Plan Identification Card, and Coordination of Care.</p> <p>f. The corrections on the Patient</p>		<p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. All documents submitted/transmitted as of 8/9/12 through 8/23/12 have been reviewed for adherence to the policy for Corrections made to the clinical record by the Director of Operations, and/or Business Office Manager.</p> <p>2. All documents will be reviewed on an ongoing basis for adherence to the policy for Corrections made to the clinical record by the Director of Operations, Business Office Manager, and/or Designee.</p> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p> <p><b>G332 – 484.55(a)(1) Initial Assessment Visit – Failure to ensure the initial assessment visit was completed within 48 hours of requested start of care date, and specifically when the initial assessment visit is delayed that the physician/referral source is notified and the reason is documented.</b></p> <p><b>Corrective Action:</b> All agency personnel received verbal instruction and written material addressing the appropriate procedure per policy for</p>				

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	<p>Emergency Plan Identification Card do not contain a date of correction.</p> <p>2. During interview on 8/3/12 at 9:00 AM, employee I indicated they went to see the patient on 7/19 but found out the patient was still receiving outpatient therapy services from another agency. Employee I indicated they notified employee A of the reason for not continuing the visit and was told to not have the patient sign the computer and to wait and return the following week to start care. Employee I indicated when they returned on 7/26 for SOC, they did not have new admission papers with them for the patient to sign, so employee I wrote over the original 19th date with the 26th on the documents. Employee I indicated they did not correctly make the changes on all documents as per agency policy.</p> <p>3. The agency's policy titled "Clinical Recorded, Late Entry and Corrections," #IM-008(c), revised 02/2012, states, "Procedure: 1. Paper Records - The use of "ditto" marks, erasures, or correction fluid / tape is not permitted. Documentation errors made in the clinical record may be corrected by drawing a single line through the word(s), initialing and dating the correction and documenting the change."</p>		<p>conducting the Admitting Assessment/Comprehensive Assessment, and the process to follow when an Admitting Assessment cannot be performed within the mandatory time frame. Reference: Policy #AA-002 Initial Referral/Admission Process, Revised 5/2011, states: "As permitted by state regulation, the admitting discipline will perform the admission assessment within 48 hours of BOTH the facility discharge AND receipt of referral, unless specified otherwise by the physician or upon special request of the patient/family/referral source. If the evaluation visit cannot be performed within the time frame, the reason should be specified within the documentation of the clinical record and the physician/referral source notified."</p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. Assessing Clinicians are responsible to immediately notify the Director of Operations when the evaluation visit cannot be performed within the mandatory time frame and verbally validate the physician has been notified of the both the delay and the reason for the delay.</p> <p>2. The Director of Operations is responsible to audit all delayed SOC documentation to ensure compliance with regulations and policy.</p>		

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NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOME HEALTH OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 LAKE AVE STE 150 FORT WAYNE, IN 46805			
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G0332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the initial assessment visit was completed within 48 hours of requested start of care date for 1 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 contained a Clinician Admit Sheet dated 7/17/12 with a Requested Start of Care (SOC) date of 7/18/12. During home visit observation with patient #4 on 8/2/12 at 10:40 AM, the admission documents in the patient's folder indicated the patient signed the documents on 7/19/12. The Plan of Care (POC) indicated a SOC date of 7/26/12; however, the patient did not know why the services were not started on 7/19 as signed.</p> <p>a. On 8/2/12, at 2:00 PM, clinical record #4 was reviewed and the original Patient Acknowledgement and Consents document in the paper portion of the clinical record indicated the 26th was</p>	G0332	<p><b>G332 – 484.55(a)(1) Initial Assessment Visit – Failure to ensure the initial assessment visit was completed within 48 hours of requested start of care date, and specifically when the initial assessment visit is delayed that the physician/referral source is notified and the reason is documented.</b></p> <p><b>Corrective Action:</b> All agency personnel received verbal instruction and written material addressing the appropriate procedure per policy for conducting the Admitting Assessment/Comprehensive Assessment, and the process to follow when an Admitting Assessment cannot be performed within the mandatory time frame. Reference: Policy #AA-002 Initial Referral/Admission Process, Revised 5/2011, states: "As permitted by state regulation, the admitting discipline will perform the admission assessment within 48 hours of BOTH the facility discharge AND receipt of referral, unless specified otherwise by the physician or upon special request of the patient/family/referral source. If the evaluation visit cannot be performed within the</p>	08/23/2012			

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	<p>written over the originally signed 19th of the documents.</p> <p>b. The Patient Acknowledgement and Consents paperwork scanned into the computer system were noted as being signed on 7/26/12.</p> <p>2. During interview on 8/3/12 at 9:00 AM, employee I indicated they went to see the patient on 7/19 but found out the patient was still receiving outpatient therapy services from another agency. Employee I indicated they notified employee A of the reason for not continuing the visit and was told to not have the patient sign the computer and to wait and return the following week to start care. Employee I indicated when they returned on 7/26 for SOC, they did not have new admission papers with them for the patient to sign, so employee I wrote over the original 19th date with the 26th on the documents.</p> <p>3. The agency's policy titled "Initial Referral/Admission Process," #AA-002, revised 05/2011, states, "Procedure ... 3. As permitted by state regulation, the admitting discipline will perform the admission assessment within 48 hours of BOTH the facility discharge AND receipt of referral, unless specified otherwise by the physician or upon special request of</p>		<p><i>time frame, the reason should be specified within the documentation of the clinical record and the physician/referral source notified."</i></p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <p>1. Assessing Clinicians are responsible to immediately notify the Director of Operations when the evaluation visit cannot be performed within the mandatory time frame and verbally validate the physician has been notified of the both the delay and the reason for the delay.</p> <p>2. The Director of Operations is responsible to audit all delayed SOC documentation to ensure compliance with regulations and policy.</p> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>				

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	patient/family referral source. If the evaluation visit cannot be performed within the time frame, the reason should be specified within the documentation of the clinical record and the physician/referral source notified."			

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G0341	<p><b>484.55(d)(3)</b> <b>UPDATE OF THE COMPREHENSIVE ASSESSMENT</b> The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure a comprehensive assessment was completed upon discharge of patients for 1 of 4 closed record reviewed with the potential to affect all the agency's discharge patients. (#10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #10, start of care date 3/16/12, indicated the patient expired and was discharged on 3/31/12. The record failed to evidence a discharge summary and comprehensive assessment with OASIS (Outcome and Assessment Information Set) data was completed as of 8/3/12.</li> <li>2. On 8/3/12 at 12:00 PM, employee S indicated the discharge summary and comprehensive assessment were not completed in the computer and the last discipline to see the patient prior to expiration would be responsible for completing the discharge portion of the record.</li> <li>3. The agency's policy titled "Oasis</li> </ol>	G0341	<p><b>G 341 – 484.55(d)(3) Update of the Comprehensive Assessment – Failure to ensure a comprehensive assessment was completed upon discharge of patients, specifically a discharge summary and comprehensive assessment were completed for a discharge with or without a visit.</b></p> <p><b>Corrective Action:</b> All agency personnel received verbal instruction and written material addressing the appropriate procedure per policy for completing comprehensive assessments, time points for completing comprehensive assessments, and process for completing discharges with or without a patient visit. Reference: Policy <u>#AA-006</u> <u>OASIS Outcome and Information Set, Revised 2/2012.</u></p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going.</p> <ol style="list-style-type: none"> <li>1. The Assessing Clinicians are responsible to call the Director of Operations to report completion of all OASIS/Comprehensive Assessments.</li> <li>2. An OASIS Process Flow</li> </ol>	08/23/2012
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	Outcome and Information Set," #AA-006, revised 02/2012, identified the agency was to complete a discharge summary if the patient expires.		<p>folder is initiated for each comprehensive assessment received by the agency to track through to completion, and there is a Process Flow Chart/Checklist specific for each type of OASIS data collection tool processed.</p> <p>3. The Business Office Manager is responsible to supervise/oversee the OASIS Process Flow for all OASIS/Comprehensive Assessment data collections to ensure transmission to the State Repository has occurred and OASIS Validation Reports are present without rejections.</p> <p>4. The Director of Operation is responsible to ensure all OASIS/Comprehensive Assessments occur and are processed per regulation and policy.</p> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</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 home visit observation, policy review, and interview, the agency failed to ensure the employees followed infection control guidelines for 2 of 5 home visits with the potential to affect all the agency's patients. (#2, 5)</p> <p>Findings include:</p> <p>1. During home visit observation with patient #2 on 8/1/12 at 12:25 PM, employee M was observed obtaining a blood pressure with a manual cuff / sphygmomanometer. Upon finishing the task, employee M put the blood pressure cuff back into its case and into the equipment bag without cleaning the cuff.</p> <p>A. During interview on 8/1/12 at 1:10 PM, employee M indicated they clean the blood pressure cuff at home in the evening.</p> <p>B. During interview on 8/1/12 at 1:50 PM, employee S indicated the policy states the cleaning of reusable equipment is to be done after each patient use.</p>	N0470	<p><b>N0470 – 484.12(c) Compliance with Accepted Professional Standards – Part One: Failure to ensure the employees followed infection control guidelines; Part Two: Failure to follow policy regarding home health aide care plans, specifically a copy of the home health aide care plan is provided to the home health aide and the patient. Corrective Action, Part One:</b> All agency personnel were instructed by 8/9/12: To ensure compliance with Accepted Professional Standards for Infection Control and Prevention, the following Amedisys policies were reviewed with all agency personnel on or before August 9, 2012, by the Director of Operations during live training sessions: 1) Infection Prevention Manual, Chapter 5 – Patient Care Polices: a) PCP-001: Hand Hygiene – specifically to the use of gloves, and triggers to change gloves during provision of patient care. b) PCP-003: Decontamination of Reusable Equipment – specifically to protocol for cleaning the equipment used to</p>	08/17/2012			

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	<p>2. During home visit observation with patient #5 on 8/2/12 at 12:00 PM, employee G, a Home Health Aide (HHA), was observed assisting the patient with a shower and then shaving the patient. During the shower, the HHA washed the patient's back and buttocks, assisted the patient to dry off and dress, and then preceded to shave the patient without changing the gloves in between tasks.</p> <p>On 8/2/12 at 1:45 PM, employee S indicated the HHA should have changed gloves after the shower.</p> <p>3. The agency's policy titled "Hand Hygiene," #PCP-001, revised 05/2011 states, "Guidelines: The need for hand washing or cleaning with an alcohol based "waterless hand cleanser" depends on the type, intensity, duration and sequence of activities. The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: 7. (*) Decontaminate hands if moving from a contaminated-body site during patient care. 15. Change gloves during patient care if moving from a contaminated body site to a clean body site."</p> <p>4. The agency's policy titled "Decontamination of Re-usable</p>		<p>assess patient vital signs and electronic medical record tools used in the patient home. 2) All clinicians and para-professionals demonstrated competency by simulated or return demonstration for the infection prevention measures reviewed as above.</p> <p><b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. The Director of Operations, or a supervising clinical designee, will perform at least one un-announced home visit with each clinician or para-professional staff member to validate 100% adherence to infection prevention practices by September 3, 2012. 2. The Director of Operations will perform a minimum of two (2) home visits with clinicians and para-professional staff members at least quarterly to validate on-going compliance. 3. The Business Office Manager, or designee, will monitor shelf to bag stock requisitions to ensure all clinicians and paraprofessionals are ordering/receiving appropriate quantities of infection prevention/decontamination supplies. <b>Completion Date:</b> Compliance will be validated at 100% by September 3, 2012, and continue at 100% on an on-going basis. <b>Corrective Action, Part Two:</b> All agency personnel were instructed on 8/9/12: To ensure compliance with policy regarding home health aide care plans, specifically that a copy of the</p>				

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	Equipment," #PCP-003, revised 05/2011, states, "Procedure: 1. Non-critical items should be cleaned in between patient use with (i.e., blood pressure cuffs, pulse oximeters, stethoscopes, tourniquets, flashlights and scales etc.) will be cleaned with 70% isopropyl alcohol or an agency approved wipe after each patient use."		home health aide care plan is provided to the home health aide and the patient, the following processes and responsibilities have been reviewed with all office and field staff: 1. The Business Office Manager, or designee, is responsible to upload/data enter each Home Health Aide Care Plan into CellTrak, the electronic medical record system used for Home Health Aide services. When entered, the original Home Health Aide Care Plan will be initialed and dated in the bottom right hand corner to indicate the plan has been entered into the Celltrak system. 2. Each Home Health Aide will verify they have access to the current Home Health Aide Care Plan prior to making visits for all assigned patients, or will contact the supervising RN for a verbal review of the Care Plan prior to providing and/or assisting with any personal care/grooming activities when access to the Home Health Aide Care Plan is not available. 3. The BOM/scheduler will verify there is a current/updated HHA Care Plan in the medical record prior to scheduling visits for the Home Health Aide. <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. Business Office Manager will review all SOC, ROC, RC packets turned in by admitting/assessing clinicians and verify: a. the yellow copy of the	

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			<p>HHA Care Plan was left in the home, b. the pink copy was given to the HHA and c. the original was entered and filed in the chart 2. Each Home Health Aide and visiting clinician will review the patient's home folder to ensure the yellow copy of the Home Health Aide Care Plan is present and current on each visit to their assigned patients receiving Home Health Aide services, and report missing documents to the supervising RN. 3. Supervising RN will take immediate steps to ensure the patient is provided with another copy of the Home Health Aide Plan to include: a. Making a photocopy of the original/most current from the medical record b. Placing the photocopy in the mailbox of the next staff member scheduled to visit the patient, with request to document delivery of copy in their visit record 4. All medical records have been audited by the Business Office Manager to verify the presence of Home Health Aide Care Plans for all patients receiving Home Health Aide Services 5. All Home Health Aides have access to CellTrac and have verified their access to the Care Plans of each assigned patient with the Business Office Manager 6. All home folders have been audited by supervising RN or field clinicians to verify the presence of Home Health Aide Care Plans for patients receiving Home Health Aide services</p>	

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			Completion Date: Validated on 08/17/12 at 100% compliance, and will continue on-going.		

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N0514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on document review, and interview, the agency failed to ensure the resolution of complaints within the time frame allotted per agency policy for 1 of 1 agency with the potential to affect all the agency's patients who complain.</p> <p>Findings include:</p> <p>1. During documentation review on 7/31/12, two Complaint / Concern Reports were noted in the agency complaint book as not completed. One was dated and recorded on 6/28/12, one was dated and recorded on 6/29/12. Both complaint forms failed to evidence the complaint / concerns were "Referred to" anyone in the agency, and both failed to evidence any "Action Taken" and "Follow-up/Resolution."</p>	N0514	<p><b>N0514 – 484.10(b)(5) Exercise of Patient Rights – Failure to ensure the resolution of complaints within the time frame allotted per agency policy . Corrective Action:</b> All agency personnel were instructed on 8/9/12: To ensure appropriate action will be taken to address all complaints, the following sections of the Amedisys Home Health Administration Manual, <u>RI-009 Patient/Caregiver Grievance/Complaint</u> policy were reviewed with all agency personnel on 08/06/12: 1. <i>The agency is to initiate a complaint investigation within 10 business days of the agency's receipt of the complaint and document all components of the investigation.</i> 2. <i>Documentation of the complaint is completed by the employee to whom the complaint is received and forwarded to the</i></p>	09/01/2012

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	<p>2. On 8/1/12 at 10:35 AM, employee S indicated the agency's policy for complaints is to bring resolution and document that resolution within 30 days.</p> <p>3. On 8/1/12 at 3:00 PM, employee S indicated the complaints from 6/28 and 6/29 were being handled by employee D who works out of two states and two of the complaints did have resolution but just weren't documented yet on the forms.</p>		<p><i>agency that includes the following:</i> 3. <i>Date of complaint</i> 4. <i>Person filing report</i> 5. <i>Person involved in complaint</i> 6. <i>Person lodging complaint</i> 7. <i>Nature of complaint(s)</i> 8. <i>Actions taken by agency's Director of Operations/designee</i> 9. <i>Response of person involved in complaint</i> 10. <i>The investigation and documentation must be completed within 30 calendar days after the agency receives the complaint, unless the agency has and documents reasonable cause for delay.</i> 11. <i>The Director of Operations, or designee, is responsible for reviewing every complaint; determining the necessity of corrective action; and communication regarding the resolution with the client, patient, caregiver, family member, consumer no later than 30 calendar days following the receipt of complaint; as well as documenting all activities involved with the complaint, investigation, analysis, resolution and communication.</i> <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. The Director of Operations is responsible to review each complaint to ensure policy is followed, and documented within the 30 day time limit. 2. In the event there is a reasonable cause for delay of the resolution process, the Director of Operations is responsible to ensure evidence of, and</p>	

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			documentation for, the delay is present. <b>Completion Date:</b> Compliance with policy will be at 100% by September 1, 2012, and continue at 100% on an on-going basis.	

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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> <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:</p> <p>(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, home visit observation, policy review, and interview, the agency failed to ensure the Plan of Care included all Durable Medical Equipment (DME) used by patients for 2 of 5 home visit observations with the potential to affect all the agency's patients. (# 3, 5)</p> <p>Findings include:</p> <p>1. During home visit observation with</p>	N0524	<p><b>N0524 – 484.18(a) Plan of Care – Failure to ensure the Plan of Care included all Durable Medical Equipment (DME) used by patients. Corrective Action:</b> All agency personnel were instructed on 8/9/12: 1. Billable and non-billable supplies provided to the patient by agency personnel, and durable medical equipment used by the patient in the home will be included on the 485/Plan of Care in the section identified as <i>Locator 14. Durable Medical Equipment and Supplies.</i></p>	08/17/2012			

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	<p>patient #3 on 8/2/12 at 10:10 AM, DME observed in the home included wheel chair, toilet riser, hemi-walker, and quad cane. The Plan of Care (POC) dated 6/14-8/12/12 failed to list these DME.</p> <p>2. During home visit observation with patient #5 on 8/2/12 at 12:00 PM, DME observed in the home included rollator walker, grab bar by bath tub, and shower bench. The POC dated 6/26-8/24/12 failed to list these DME.</p> <p>3. The agency's policy titled "Plan of Care (POC)/Care Planning Process," #AA-014, revised 05/2011, states, "484.18(a) Standard: Plan of Care: the plan of care developed in consultation with the agency staff cover all pertinent diagnoses, including mental status, types of services and equipment required. ... 3. Documentation of the Care Planning Process includes, but is not limited to the following information: CMS 485 (POC)."</p> <p>4. On 8/2/12 at 1:45 PM, employee S agreed the DME should be listed on the POC.</p>		<p>2. Policy <u>AA-014, Plan of Care/Care Planning Process</u>, revised 5/2011, was reviewed with particular attention to identifying the types of DME and supplies the patient uses and/or requires for home use. Rehab Clinicians responsible for Therapy Only Comprehensive Assessments/Reassessments and development of the Plan of Care received additional training regarding identification of, and steps to ensure inclusion of DME and Supplies in the 485/Plan of Care. <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. The Director of Operations will review all 485/Plan of Care documents for compliance before certifying. 2. The Business Office Manager will review all 485/Plan of Care documents for compliance before sending to the physician for signature. <b>Completion Date:</b> 100% Compliance achieved 8/17/12, and will continue on an on-going basis.</p>		

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N0547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse obtained verbal orders from the physician for new medications for 2 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#1 and 3)</p> <p>Findings include:</p> <p>1. During home visit observation on 8/1/12 at 8:45 AM, employee F was observed talking with patient #1 about taking Tylenol and Miralax. The patient indicated to employee F that they take both Tylenol and Miralax "every now and then." The Visit Note dated 7/16/12 indicated the Licensed Practical Nurse (LPN) "obtained an order for Tylenol for pain and pt [patient] has been using it some over the week-end and stated it does help." Under the section titled "Medications" the skilled nurse (SN) failed to indicate the start/change date as prompted by the documentation. The record failed to evidence an order was</p>	N0547	<p><b>N0547 – 484.18(c) Conformance with Physician Orders – Failure to ensure the registered nurse obtained verbal orders from the physician for new medications. Corrective Action:</b> All agency personnel were instructed on 8/9/12: 1. A physician order is required for all services, medications and treatments 2. Medications include, but are not limited to, prescriptions, over-the-counter, herbal, homeopathic, etc. 3. All verbal physician orders will be put in written format as soon as possible after receipt, the same day as received. 4. All verbal physician orders received by the LPN will be validated and co-signed by the RN prior to implementation. 5. Medication orders must be clearly communicated to all members of the team when a change occurs. <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. All verbal physician orders will be written, signed and dated the receiving the clinician the same day the order is received, transmitted</p>	08/23/2012			

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	<p>written and obtained from the physician for the Tylenol.</p> <p>The Visit Note dated 7/25/12 indicated the patient told employee F they are concerned about the bowels not moving as well as they thought they should be and that the patient has Miralax from the hospital. The Visit Note indicated employee F told the patient how to use it either daily or every other day to see if the patient felt better. Under the section titled "Medication" employee F indicated "no change since last visit" and the document failed to evidence the physician was notified and/or orders were obtained for the Miralax. The document failed to evidence further attempts to obtain an order for Miralax.</p> <p>2. Clinical record #3, start of care 6/14/12, contained a Skilled Nurse Visit Note dated 6/18/12 which indicated a "Medication change since last visit" of Cipro 250 mg by mouth twice daily: began 6.15.12 and "Orders obtained." The record failed to evidence the orders were obtained.</p> <p>3. The agency's policy titled "Medication Administration," #MA-001, revised 02/2012, states, "B. Medication Order Guidelines: 1. Whenever possible, the practitioner should request that a written</p>		<p>electronically the agency, and reviewed by the Director of Operations. 2. All changes to medication orders will be communicated to all members of the team, and communication regarding the changes will be documented in the communication/coordination of care section of the visit record by the clinician receiving the order, or via a clinical note addendum the same day the change occurs. 3. The Director of Operations will review all verbal physician orders obtained by the LPN to ensure compliance with validation and counter-signature by the RN requirements. <b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>		

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	<p>medication administration order be sent to the home health agency. 2. Medication orders received must be written, signed and dated by the licensed prescriber. Order must be obtained as soon as possible. 5. It is imperative that medication orders be clearly communicated with all members of the health care team. *Note: The clinician should contact the physician or prescriber by any means at their disposal to determine or verify the components and intent of the medication order before administration of the medication. The physician/prescriber should be called or paged or the order faxed to the physician for clarification. Verification of the order is considered a priority and all attempts to verify must be documented in the medical record. C. Telephone Orders: 3. The following protocol will be used in taking verbal or telephone orders for medication. The practitioner receiving the verbal order will: a. Write the order or enter it into the computer immediately;"</p> <p>4. The agency's policy titled "Services Provided/Supervision of Disciplines-RN/LPN," #AA-007(a), revised 05/2012, states, "III. Licensed Practical Nurse (LPN/LVN) ... Verbal physician orders received by the LPN/LVN will be validated and co-signed by the RN prior to implementation."</p>			

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on home visit observation, interview, and policy review, the agency failed to ensure the Registered Nurse (RN) assigned only tasks the Aide is allowed to perform per policy for 1 of 1 home visit with HHA services with the potential to affect all the agency's patients who receive HHA services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a Home Health Aide Care Plan dated 6/26/12. Under the section titled Personal Care, the RN assigned Nail care to be done every visit.</p> <p>2. The agency's policy titled "Home Health Aide Care Plan/Assignment," #AA-011, revised 07/2012 states, "Procedure: ... 9. Tasks that will NOT be delegated to the Home Health Aide: Clipping and filing nails."</p>	N0550	<p><b>N0550 – 484.36(c)(1) Assignment &amp; Duties of Home Health Aide – Failure to ensure the Registered Nurse (RN) assigned only tasks the Aide is allowed to perform per policy, specifically Nail Care. Corrective Action:</b> All agency personnel were instructed on 8/9/12: 1. The Home Health Aide provides personal care and grooming activities as assigned by the RN 2. The RN assigns only tasks the Aide is allowed to perform 3. The Aide immediately contacts the Supervising RN/Therapist when assigned tasks are identified that are not on the approved task/allowed skill list per policy. 4. Policy <u>#AA-011, Home Health Aide Care Plan/Assignment</u>, revised 7/2012, was reviewed with all supervising clinicians and Home Health Aides to ensure the tasks allowed and not allowed for the Aide to perform were clearly understood by all parties. <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. The Director of Operations is responsible to review all</p>	08/23/2012			

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			<p>new/changed/updated Home Health Aide Care Plans for compliance with appropriate/approved Home Health Aide task assignment. 2. The Business Office Manager is responsible to review all Home Health Aide Care Plans uploaded to CellTrac for appropriate/approved Home Health Aide task assignment. 3. The Supervising RN is responsible to review all Home Health Aide Care Plans during supervisory visits to ensure only tasks the Aide is allowed to perform are assigned.</p> <p><b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>	

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on employee file reviews, policy review, and interview, the agency failed to ensure the Home Health Aide (HHA) was entered on and in good standing on the Indiana State Aide Registry for 1 of 1 HHA files reviewed with the potential to affect all the agency patients. (G)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Employee file G, a HHA, date of hire 1/3/12, failed to evidence the agency had checked the Indiana State Aide Registry to verify the HHA was entered on and in good standing on the registry. The file also failed to evidence the agency had completed the documentation for application of the Home Health Aide number.</li> <li>On 8/3/12 at 3:00 PM, employee S indicated the agency checked the Indiana State Aide Registry for employee G's HHA number using both current and a maiden or former name. The number was not on the registry.</li> <li>The agency's job description titled "Home Health Aide," dated August 2010,</li> </ol>	N0597	<p><b>N597 410 IAC 17-14-1(l)(1)(B)</b> Scope of Services – The home health aide shall be entered on and be in good standing on the state aide registry. <b>Corrective Action:</b> All patient care activities of home health aide were immediately suspended. Home health aide information submitted to the state for addition of aide on state registry. Agency received confirmation on 8/14/12 that home health aide is on and is in good standing with the state registry. <b>Monitoring Process:</b> 1. Proof of registry will be verified and printed for all new hires prior to any patient care activities. <b>Completion Date:</b> 100% compliance achieved 8/14/12 and continues on going.</p>	08/14/2012

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	states under the section titled "State-Specific Qualifications, - Indiana State Specific: (1) The home health aide shall: ... (B) be entered on and be in good standing on the state aide registry."			

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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 corrections made in the clinical record were made according to agency policy for 1 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 contained a Clinician Admit Sheet dated 7/17/12 with a Requested Start of Care (SOC) date of 7/18/12. During home visit observation with patient #4 on 8/2/12 at 10:40 AM, the admission documents in the patient's</p>	N0608	<p><b>N0608 – 484.48 Clinical Records – Failure to ensure corrections made in the clinical record were made according to policy, specifically a single line through the error, noted as error and initialed with date, to be followed with documentation of the correct information immediately above or following the error.</b></p> <p><b>Corrective Action:</b> All agency personnel received verbal instruction and written material addressing the appropriate procedure per policy for corrections made in the clinical record. Reference: Policy <u>#IM-008(c) Clinical Record, Late</u></p>	08/23/2012

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	<p>folder indicated the patient signed the documents on 7/19/12. The Plan of Care (POC) indicated a SOC date of 7/26/12; however, the patient did not know why the services were not started on 7/19 as signed.</p> <p>a. On 8/2/12, at 2:00 PM, clinical record #4 was reviewed, and the original Patient Acknowledgement and Consents document in the paper portion of the clinical record indicated the 26th was written over the originally signed 19th of the documents.</p> <p>b. The Patient Acknowledgement and Consents paperwork scanned into the computer system were noted as being signed on 7/26/12.</p> <p>c. The record failed to evidence the physician was notified of a later SOC date.</p> <p>d. The Clinician Admit Sheet dated 7/17/2012 contains three corrections to the document each with a line through the information needing to be corrected, but failed to evidence date and initials.</p> <p>e. The dates of patient and employee signatures were not properly indicated as corrections per policy on the following documents: the Patient</p>		<p><u>Entry and Corrections</u>, revised 2/2012, states: "Documentation errors made in the clinical record may be corrected by drawing a single line through the word(s) [error], initialing and dating the correction and documenting the change." <b>Monitoring Process:</b> Until 100% compliance achieved, and on-going. 1. All documents submitted/transmitted as of 8/9/12 through 8/23/12 have been reviewed for adherence to the policy for Corrections made to the clinical record by the Director of Operations, and/or Business Office Manager. 2. All documents will be reviewed on an ongoing basis for adherence to the policy for Corrections made to the clinical record by the Director of Operations, Business Office Manager, and/or Designee. <b>Completion Date:</b> 100% compliance achieved 08/23/12, and continues on going.</p>		

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	<p>Acknowledgements and Consents form page 3, Universal Precautions and Patient's Rights, Patient Emergency Plan Identification Card, and Coordination of Care.</p> <p>f. The corrections on the Patient Emergency Plan Identification Card do not contain a date of correction.</p> <p>2. During interview on 8/3/12 at 9:00 AM, employee I indicated they went to see the patient on 7/19 but found out the patient was still receiving outpatient therapy services from another agency. Employee I indicated they notified employee A of the reason for not continuing the visit and was told to not have the patient sign the computer and to wait and return the following week to start care. Employee I indicated when they returned on 7/26 for SOC, they did not have new admission papers with them for the patient to sign, so employee I wrote over the original 19th date with the 26th on the documents. Employee I indicated they did not correctly make the changes on all documents as per agency policy.</p> <p>3. The agency's policy titled "Clinical Recorded, Late Entry and Corrections," #IM-008(c), revised 02/2012, states, "Procedure: 1. Paper Records - The use</p>			

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	of "ditto" marks, erasures, or correction fluid / tape is not permitted. Documentation errors made in the clinical record may be corrected by drawing a single line through the word(s), initialing and dating the correction and documenting the change."			