

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K081	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
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NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 703 W CHAPEL PIKE MARION, IN 46952
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G 000 Bldg. 00	<p>This visit was a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: April 1, 2, 6, and 7, 2015</p> <p>Facility #: 012691</p> <p>Medicaid Vendor #: 201058750</p> <p>Census (Unduplicated last 12 months): 113</p> <p>QA:JE 4/14/15</p>	G 000		
G 108 Bldg. 00	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review, admission packet review, and interview,</p>	G 108	Deficiency was corrected by revising our current missed visit form. We added; time client was notified, and a section to show	04/08/2015

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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	<p>the agency failed to ensure the patient was informed of any changes in the care to be furnished in 2 of 7 active patient records reviewed creating the potential to affect all the agency's current 113 patients. (#1 and #7)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a Home Health Certification and Plan of Care for certification period 2/4 to 4/4/15 with orders to include home health aide services 5-6 hours per day, 1-2 visits per day, 6-7 days per week for 60 days to assist with ADL's (activities of daily living), meal preparation, medication reminders, and to keep work area clean. The record failed to evidence aide visits were conducted on 2/24/15 and 3/1/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document titled "MISSED VISITS" stating, "Date of Missed Visit(s): '2/24/15' Time of Missed Visit(s): '10 a [AM] - 4 p [PM]' ... This is to notify that based on your order visit frequency; a home visit(s) was/were not made on the date(s) noted by the discipline and for the following reason(s). ... Aide [checked] ... Inclement Weather [checked]"</p>		<p>how the clients needs will be met. Once completed this form will continue to be faxed to the Physician and filed into the clients medical record. This was added to the missed visit form to ensure that accurate documentation of client notification and any interruptions of services or frequency changes in the plan of care. To prevent that this does not recur "1" employee is assigned to complete, track, fax and notify client/family member of a missed visit. The Administrator, DON, ADON are all responsible for ensuring missed visits are completed correctly, timely and that proper notification was given to the client/family caregiver. All missed visits will be discussed in the morning meeting before the start of each day. The missed visits will be re-verified through daily review of all missed visit documentation. This will continue indefinitely by one of the three members of management, to safeguard that this does not recur.</p>	

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	<p>B. The record evidenced a document titled "MISSED VISITS" stating, "Date of Missed Visit(s): '3/1/15' Time of Missed Visit(s): '10 - 4 p' ... This is to notify that based on your order visit frequency; a home visit(s) was/were not made on the date(s) noted by the discipline and for the following reason(s). ... Aide [checked] ... Inclement Weather [checked]"</p> <p>C. On 4/6/15 at 10:25 AM, employee A (administrator) indicated being unable to locate documentation of the patient's notification of the the missed visits.</p> <p>2. Clinical record #7, start of care 1/27/15, contained a Home Health Certification and Plan of Care for certification period 1/27 to 3/27/15 with orders for home health aide services 1-2 hours per day, 3-5 days per week for 60 days to assist with ADL's, meal preparation, medication reminders, and to keep work area clean. The record failed to evidence a third aide visit was conducted week 1 and failed to evidence aide visits were conducted week 6.</p> <p>On 4/7/15 at 2:10 PM, employee B (director of nursing) indicated being unable to locate documentation of a third aide visit for week 1. The employee</p>			

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	<p>indicated being unable to locate documentation of any aide visits conducted week 6 and was unable to locate documentation of the patient's notification of the missed visits.</p> <p>3. The agency admission packet contained a document with an effective date of 9/1/2011 and a revised date as 8/2014 titled "CLIENT HANDBOOK" stating (page 15 of 17), "PATIENT RIGHTS AND RESPONSIBILITIES New Horizons Home Healthcare staff assures that patient rights are honored and that all patients are aware of their responsibilities in the care process. ... Patient Rights The Patient Has The Right: ... 5. To be fully informed in advance about service/care to be provided, including the disciplines that furnish care and the frequency of visit as well as any modifications to the service/care plan. ... 7. To participate in the development and periodic revision of the plan of care/service, and any modifications to the plan of care, in advance of care being provided or before a change is made in the plan of care."</p>			

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G 158 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care for 1 of 7 active patient records reviewed creating the potential to affect all 113 of the agency's current patients. (#7)</p> <p>Findings include:</p> <p>1. Clinical record #7, start of care 1/27/15, contained a Home Health Certification and Plan of Care for certification period 1/27 to 3/27/15 with orders for home health aide services 1-2 hours per day, 3-5 days per week for 60 days to assist with ADL's, meal preparation, medication reminders, and to keep work area clean. The record failed to evidence a third aide visit was conducted week 1 and failed to evidence aide visits were conducted week 6.</p> <p>On 4/7/15 at 2:10 PM, employee B (director of nursing) indicated being</p>	G 158	<p>This deficiency was corrected by implementing a Missed Visit Policy and Procedure. All Staff will have been in-serviced on this policy and what constitutes the need to write a missed visit form or if that visit can be made up in the week as long as it falls in the ranges on the physician order. 04/17/2015 is date in which all staff will be in-serviced by. 04/08/2015 The scheduling coordinator was assigned to be in charge of missed visits, she is to complete, track, notify client/ family member, and fax missed visits to physician. Administrator, DON or designee is responsible for monitoring and ensuring that this is completed timely and correctly. We will discuss all missed visits in the morning office meetings. We will re-verify through daily review that missed visit forms were completed or the need to reschedule visit can be done and fall in the ranges ordered by the physician. This will continue from this day forward, to assure there is no recurrence of deficiency.</p>	04/17/2015

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G 225 Bldg. 00	<p>unable to locate documentation of a third aide visit for week 1 or documentation of any aide visits conducted week 6.</p> <p>2. The undated agency policy titled "PLAN OF CARE" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members. ... "</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on clinical record review, policy review, and interview, the agency failed to ensure the home health aide provided services that were ordered by the physician in the plan of care in 3 of 7 active patient records reviewed of patients receiving home health aide services creating the potential to affect all patients of the agency receiving home health aide services. (#1, #7, and #10)</p> <p>Findings include:</p>	G 225	To correct this deficiency we revised the home health aides visit notes to reflect a "C" column, this is to be checked when tasks has been completed. A "R" column was added to be checked to show that the client has refused task to be provided. On 04/10/2015 The Administrator, DON and ADON in-serviced all RN's/Case Managers on how to correctly write the home health aides care plans. They are to continue to write in the frequencies on all personal care	04/08/2015

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	<p>1. Clinical record #1, start of care 8/8/14, contained a Home Health Certification and Plan of Care for certification period 2/4 to 4/4/15 with orders to include home health aide services 5-6 hours per day, 1-2 visits per day, 5-7 days per week for 60 days to assist with ADL's (activities of daily living), dressing, bathing to prevent skin breakdown, assistance with ambulating in and out of the bathtub, grooming, toileting, perineal care, meal preparation, medication reminders, and cleaning of work area. The record contained a home health aide care plan with dates of review by the registered nurse as 2/2/15 and 3/14/15 to include the tasks of assisting with bathing and perineal care.</p> <p>1. The record failed to evidence the home health aide completed the task of complete/partial bed bath, assist with tub/shower/chair on 2/3, 2/4, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/16, 2/17, 2/18, 2/19, 2/20, 2/23, 2/26, 2/28, 3/3, 3/7, 3/10, 3/11, and 3/12/15.</p> <p>2. The record failed to evidence the home health aide completed the task of perineal care on 2/3, 2/4, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/16, 2/17, 2/18, 2/23, 2/26, 3/3, 3/7, 3/10, 3/11, and 3/12/15.</p>		<p>tasks as well as checking the box indicating "per patient request". On 04/17/2015 A in-service for all home health aides was given. They were instructed on how to properly use the new revised visit notes, and to assure that they are always providing personal care, if the client is continually refusing to have specific personal care tasks completed they are to report to the Case Manager, or Administrator, DON or ADON immediately as this may mean that the clients health condition has declined and we need to be aware of any changes so that an assessment can be completed and the Physician notified. The Medical Records Clerk/Receptionist is assigned to monitor all home health aide visit notes on a weekly basis, prior to being filed into the clients clinical record. This will continue from this day forward, thus to ensure that all home health aides are following clients care plan and to monitor the refusal of client care. This employee will report these refusals to the DON and Administrator, therefore to make a decision that a nurse visit needs to be made or the physician to be notified. The DON and ADON will monitor/audit all patient records at 25% for the next 4 months until 100% completion to ensure that we are properly notifying and documenting in all areas. This will continue every quarter to ensure that this deficiency does not</p>				

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	<p>2. Clinical record #7, start of care 1/27/15, contained a Home Health Certification and Plan of Care for certification period 1/27 to 3/27/15 with orders to include home health aide services 1-2 hours per day, 3-5 days per week for 60 days to assist with ADL's, dressing, bathing, assistance with ambulating in and out of the bathtub, grooming, toileting, perineal care, meal preparation, medication reminders, and cleaning of work area.</p> <p>The record contained a home health aide care plan dated 1/27/15 with dates of review by the registered nurse as 3/24 and 3/29/15 to include the tasks of assisting with bathing, oral care, skin care, and perineal care 3-5 times per week.</p> <p>1. The record failed to evidence the home health aide completed the personal care task of oral care, skin care, and perineal care during the 2 visits made week 1.</p> <p>2. The record failed to evidence the home health aide completed the personal care task of oral care, skin care, and perineal care during the 4 visits made week 2.</p> <p>3. The record failed to evidence</p>		<p>recur. We will continue in each monthly in-service for the next four months to instruct the home health aides on the importance of following clients care plans as well as documenting and reporting changes and refusals. This will ensure there will be no further recurrences on this deficiency.</p>	

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	<p>the home health aide completed the personal care task of oral care, skin care, and perineal care during the 3 visits made week 3.</p> <p>4. The record failed to evidence the home health aide completed the personal care task of oral care, skin care, and perineal care during the 5 visits made week 4.</p> <p>5. The record failed to evidence the home health aide completed the personal care task of oral care, skin care, and perineal care during the 3 visits made week 5.</p> <p>6. The record failed to evidence the home health aide completed the personal care task of oral care, skin care, and perineal care during the 4 visits made week 7.</p> <p>7. The record failed to evidence the home health aide completed the personal care task of oral care and perineal care during the 3 visits made week 8. The home health aide provided the personal care task of assistance with bathing and skin care 1 time week 8.</p> <p>8. The record failed to evidence the home health aide completed the personal care task of oral care and</p>						

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	<p>perineal care during the 4 visits made week 9. The home health aide provided the personal care task of skin care 1 time week 8.</p> <p>3. Clinical record #10, start of care 9/16/14, contained a Home Health Certification and Plan of Care for certification period 3/15 to 5/13/15 with orders to include home health aide services 2-4 hours per day, 1-2 visits per day, 5-7 days per week for 60 days to assist with ADL's, dressing, bathing, assistance with ambulating in and out of the bathtub, grooming, toileting, perineal care, meal preparation, medication reminders, and cleaning of work area.</p> <p>A. The record contained a home health aide care plan dated 11/14/14 with dates of review by the registered nurse as 1/13 and 3/13/15 to include the tasks of assisting with bathing 3-7 times per week.</p> <p>The record failed to evidence the home health aide completed the personal care task of assistance with bathing during the 7 visits made week 2.</p> <p>B. On 4/7/15 at 2:02 PM, employee B (director of nursing) indicated the home health aide did not document why this task was not completed. The</p>			

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N 000 Bldg. 00	<p>employee indicated if the patient refuses, the aide is to notify the case manager and the refusal is then documented.</p> <p>4. On 4/6/15 at 10:26 AM, employee B (director of nursing) indicated home health aides should be providing tasks as ordered on the care plan.</p> <p>5. The undated agency policy titled "HOME HEALTH AIDE CARE PLAN" states, "POLICY A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan."</p> <p>This visit was a home health State licensure survey.</p> <p>Survey Dates: April 1, 2, 6, and 7, 2015</p> <p>Facility #: 012691</p> <p>Medicaid Vendor #: 201058750</p>	N 000		

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N 504 Bldg. 00	<p>Census (Unduplicated last 12 months): 113</p> <p>QA:JE 4/14/15</p> <p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review, admission packet review, and interview, the agency failed to ensure the patient was informed of any changes in the care to be furnished in 2 of 7 active patient records reviewed creating the potential to affect all the agency's current 113 patients. (#1 and #7)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a Home Health Certification and Plan of Care for certification period 2/4 to 4/4/15 with orders to include home health aide services 5-6 hours per day,</p>	N 504	<p>Deficiency was corrected by revising our current missed visit form. We added; time client was notified, and a section to show how the clients needs will be met. Once completed this form will continue to be faxed to the Physician and filed into the clients medical record. This was added to the missed visit form to ensure that accurate documentation of client notification and any interruptions of services or frequency changes in the plan of care. To prevent that this does not recur "1" employee is assigned to complete, track, fax and notify client/family member of a missed visit. The Administrator, DON, ADON are all responsible for</p>	04/08/2015

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	<p>1-2 visits per day, 6-7 days per week for 60 days to assist with ADL's (activities of daily living), meal preparation, medication reminders, and to keep work area clean. The record failed to evidence aide visits were conducted on 2/24/15 and 3/1/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document titled "MISSED VISITS" stating, "Date of Missed Visit(s): '2/24/15' Time of Missed Visit(s): '10 a [AM] - 4 p [PM]' ... This is to notify that based on your order visit frequency; a home visit(s) was/were not made on the date(s) noted by the discipline and for the following reason(s). ... Aide [checked] ... Inclement Weather [checked]"</p> <p>B. The record evidenced a document titled "MISSED VISITS" stating, "Date of Missed Visit(s): '3/1/15' Time of Missed Visit(s): '10 - 4 p' ... This is to notify that based on your order visit frequency; a home visit(s) was/were not made on the date(s) noted by the discipline and for the following reason(s). ... Aide [checked] ... Inclement Weather [checked]"</p> <p>C. On 4/6/15 at 10:25 AM, employee A (administrator) indicated being unable</p>		<p>ensuring missed visits are completed correctly, timely and that proper notification was given to the client/family caregiver. All missed visits will be discussed in the morning meeting before the start of each day. The missed visits will be re-verified through daily review of all missed visit documentation. This will continue indefinitely by one of the three members of management, to safeguard that this does not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K081	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
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	<p>to locate documentation of the patient's notification of the the missed visits.</p> <p>2. Clinical record #7, start of care 1/27/15, contained a Home Health Certification and Plan of Care for certification period 1/27 to 3/27/15 with orders for home health aide services 1-2 hours per day, 3-5 days per week for 60 days to assist with ADL's, meal preparation, medication reminders, and to keep work area clean. The record failed to evidence a third aide visit was conducted week 1 and failed to evidence aide visits were conducted week 6.</p> <p>On 4/7/15 at 2:10 PM, employee B (director of nursing) indicated being unable to locate documentation of a third aide visit for week 1. The employee indicated being unable to locate documentation of any aide visits conducted week 6 and was unable to locate documentation of the patient's notification of the missed visits.</p> <p>3. The agency admission packet contained a document with an effective date of 9/1/2011 and a revised date as 8/2014 titled "CLIENT HANDBOOK" stating (page 15 of 17), "PATIENT RIGHTS AND RESPONSIBILITIES New Horizons Home Healthcare staff assures that patient rights are honored</p>			

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N 522 Bldg. 00	<p>and that all patients are aware of their responsibilities in the care process. ... Patient Rights The Patient Has The Right: ... 5. To be fully informed in advance about service/care to be provided, including the disciplines that furnish care and the frequency of visit as well as any modifications to the service/care plan. ... 7. To participate in the development and periodic revision of the plan of care/service, and any modifications to the plan of care, in advance of care being provided or before a change is made in the plan of care."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care for 1 of 7 active patient records reviewed creating the potential to affect all 113 of the agency's current patients. (#7)</p>	N 522	<p>This deficiency was corrected by implementing a Missed Visit Policy and Procedure. All Staff has been in-serviced on this policy and what constitutes the need to write a missed visit form or if that visit can be made up in the week as long as it falls in the ranges on the physician order. 04/17/2015 is date in which all</p>	04/17/2015

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	<p>Findings include:</p> <p>1. Clinical record #7, start of care 1/27/15, contained a Home Health Certification and Plan of Care for certification period 1/27 to 3/27/15 with orders for home health aide services 1-2 hours per day, 3-5 days per week for 60 days to assist with ADL's, meal preparation, medication reminders, and to keep work area clean. The record failed to evidence a third aide visit was conducted week 1 and failed to evidence aide visits were conducted week 6.</p> <p>On 4/7/15 at 2:10 PM, employee B (director of nursing) indicated being unable to locate documentation of a third aide visit for week 1 or documentation of any aide visits conducted week 6.</p> <p>2. The undated agency policy titled "PLAN OF CARE" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members. ... "</p>		<p>staff will be in-serviced by 04/08/2015. The scheduling coordinator was assigned to be in charge of missed visits, she is to complete, track, notify client/family member, and fax missed visits to physician. Administrator, DON or designee is responsible for monitoring and ensuring that this is completed timely and correctly. We will discuss all missed visits in the morning office meetings. We will re-verify through daily review that missed visit forms were completed or the need to reschedule visit can be done and fall in the ranges ordered by the physician. This will continue from this day forward, to assure there is no recurrence of deficiency.</p>		