

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2015
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NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON ST SYRACUSE, IN 46567
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G 000  Bldg. 00	<p>This was a home health federal recertification survey. This was an extended survey.</p> <p>Survey Dates: April 20-28, 2015. Partial Extended Dates: April 21, 22, 23, 2015. Extended Dates: April 24, 27, and 28, 2015.</p> <p>Facility Number: IN0012779</p> <p>Medicaid Number: 201068710A</p> <p>Census Service Type: Skilled: 1 Home Health Aide Only: 61 Personal Care Only: 0 Total: 62</p> <p>Sample: RR w/HV: 4 RR w/o HV: 7 HV w/o RR: 1 Total: 12</p> <p>Forte Home Health Care, Inc. is precluded from providing its own training and competency evaluation</p>	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 102 Bldg. 00	<p>program for a period of 2 years beginning April 28, 2015, through April 28, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide Services, and 42 CFR 484.48: Clinical Records.</p> <p>QA:JE 5/6/15</p> <p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure patients received Outcome and Assessment Information Set (OASIS) privacy rights prior to providing care and collecting OASIS information for 1 of 1 qualifying clinical record reviewed. (# 1)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care date 4/22/13, contained a plan of care dated 2/8-4/9/15 with orders for skilled nursing 3-13 hours 3-7 days per week for a total of up to 91 hours per week times 60 days.</p>	G 102	<p>1. OASIS Privacy Rights will be provided to current OASIS patient during home visit to occur 5/18/15. 2. OASIS Privacy Rights will be provided to all OASIS patients upon initial assessment. 3. Administrator responsible for correction and compliance.4. 05/18/2015</p>	05/18/2015

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	<p>The clinical record failed to evidence the patient had received notice of OASIS privacy rights.</p> <p>2. During home visit observation on 4/21/15 at at 10:00 AM, the home admission packet failed to evidence OASIS privacy rights information.</p> <p>3. During interview on 4/23/15 at 9:23 AM, employee B, the administrator, indicated the agency does not have a separate OASIS privacy statement.</p> <p>4. The agency's policy titled "Client Rights and Responsibilities Notification," # 5.9, dated 3/1/14, states "Forte HHC [Home Health Care] acknowledges that the client has the right to be informed of his or her rights. Forte HHC strives to protect and promote the exercise of these rights and will complete the following: 1) Provide the client with a written notice of the client's rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment. 2) Maintain documentation showing that it has complied with the requirements of this section."</p>			

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G 110  Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document and policy review, clinical record review, and observation, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 1 of 4 home visit observations. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/22/13, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 4/21/15 at 10 AM, a home visit was conducted to patient #1. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p>	G 110	<p>1. Agency audit of each home binder to ensure proper, updated Advanced Directives document (July 2013) is in each home.</p> <p>2. Updated Advanced Directives are given to each client upon admission.</p> <p>3. Administrator</p> <p>4. 5/28/15</p>	05/28/2015	

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G 121 Bldg. 00	<p>2. During interview on 4/23/15 at 9:22 AM, employee A, nursing supervisor, indicated the agency missed getting the updated Advance Directives packet to patient #1.</p> <p>3. The agency's policy titled "Client Rights and Responsibilities Notification," # 5.9, dated 3/1/14, states "Forte HHC [Home Health Care] acknowledges that the client has the right to be informed of his or her rights. Forte HHC strives to protect and promote the exercise of these rights and will complete the following: ... 13) Forte HHC will comply with the requirements of subpart 1 of part 489 of this state and federal regulations relating to maintaining written policies and procedures regarding advance directive and will inform and distribute written information to the client, in advance, concerning its policies on advance directives, including a description of applicable State law."</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p>			

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	<p>Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 3 of 4 home visit observations. (# 1, 2, and 3)</p> <p>Findings include</p> <p>1. During home visit observation on 4/21/15 at 10 AM with patient #1, employee H, a licensed practical nurse (LPN), was observed providing trach care, oral care, and a bed bath.</p> <p>A. Employee H removed the old trach dressing, wiped around the trach, prepared dressing with cream, and applied the new dressing to the trach site. Employee H failed to don clean gloves after removing old dressing and prior to placing clean dressing to trach site.</p> <p>B. Employee H failed to don gloves while performing oral care.</p> <p>C. During the bed bath, employee H failed to perform hand washing or use hand sanitizer after removing patient's pants and prior to donning clean gloves.</p> <p>D. During the bed bath, employee H failed to change the bath water.</p> <p>E. During the bed bath, employee H</p>	G 121	<p>1. Staff education and competency testing in process for all direct care staff, including nurses, who provide direct care, to include policies and procedures for handwashing, medical gloves, bathing, and infection control.</p> <p>2. Agency to complete annual training for home health aides, in the area of infection control. Supervisory visits to include observation of personal care and monitoring to ensure that infection control practices are being correctly implemented by staff performing the care (both nurses and home health aides).</p> <p>3. Nursing Supervisor 4. 5/28/15</p>	05/28/2015			

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	<p>failed to wash patient's perineum.</p> <p>F. During interview on 4/23/15 at 9:30 AM, employee A, nursing supervisor, indicated once dirty items are disposed of, staff should be washing hands or using sanitizer prior to donning new gloves and applying anything clean. Employee A indicated she does not know why the LPN failed to wash the patient's perineum.</p> <p>G. During interview on 4/23/15 at 9:31 AM, employee B, the administrator, indicated typically the agency teaches staff to change the bath water after a dirty area has been washed and to ensure warm water.</p> <p>2. During home visit observation on 4/22/15 at 9 AM, employee J, a home health aide (HHA), was observed providing a shower to patient #2. During the shower, employee J washed the patient's buttocks, and then proceeded to wash the patient's perineal area and proceeded to rinse the patient's hair. Employee J failed to obtain a clean wash cloth and change gloves prior to washing the perineal area.</p> <p>During interview on 4/23/15 at 9:32 AM, both employees A and B, indicated patients' should always be washed from</p>			

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	<p>front to back.</p> <p>3. During home visit observation on 4/23/15 at 10:30 AM, employee K, a HHA, was observed providing perineal care to patient #3. Employee K failed to wash hands or use sanitizer in between removing dirty gloves and prior to donning clean gloves.</p> <p>4. During interview on 4/23/15 at 9:33 AM, employee B indicated employees should be washing hands or using sanitizer prior to donning clean gloves, in between glove changes, and when they have completed care.</p> <p>5. The agency's policy titled "Bed Bath Policy and Procedure," no number, dated 5/9/12, states, "12) ... wash her shoulders, back, side, hips and down to the foot and toes. Rinse the soap away and dry the wet areas with a towel. Change the water in the basins. ... 14) Wash the client's genitals quickly to limit his discomfort. ... Wash a woman's labia."</p> <p>6. The agency's policy titled "Handwashing Policy and Procedure," no number, dated 5/18/12, states, "1. Indications for handwashing and hand antisepsis. ... Wash hands ... after removing gloves; before handling an</p>			

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G 141 Bldg. 00	<p>invasive device (regardless of whether or not gloves are used) for patient care; ... if moving from a contaminated body site to a clean body site during patient care."</p> <p>7. The agency's undated policy titled "Proper Use of Medical Gloves," no number, states, "Removing Gloves ... Discard these gloves in the proper receptacle and immediately wash hands thoroughly. Work from clean to dirty."</p> <p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on employee file review, policy review, and interview, the agency failed to ensure all personnel policies were followed for 1 of 8 employee files reviewed. (Employee D)</p> <p>Findings include</p> <p>1. Employee file D, a home health aide, date of hire 8/30/12, contained a physical dated 6/11/12. The form failed to contain a signature of the physician or nurse</p>	G 141	<p>1. Employee D received a new employment physical on 5/12/15</p> <p>2. All employee records were audited and reviewed to ensure that physicals were completed and that licenses are current. New employees receive a pre-employment physical not more than 180 days before they have direct client contact.</p> <p>3. Administrator 4. 5/12/15</p>	05/12/2015

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G 145 Bldg. 00	<p>practitioner (NP) who performed the assessment.</p> <p>2. During interview on 4/28/15 at 10:20 AM, employee B, the administrator, indicated she noticed this file's physical was not signed, and the physical was performed by the previous NP who used to work here.</p> <p>3. The agency's policy titled "Employee Files Content," # 6.7, dated 3/1/14, states "Forte HHC employee files shall be kept current and include: ... 12) Physical examinations-Each employee who will have direct client contact shall have a physical examination by a physician or nurse practitioner not more than one hundred eighty (180) days before the date that the employee has direct client contact."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Based on clinical record review, policy review, and interview, the agency failed to ensure a 60 day summary was sent to the physician for 7 of 11 clinical records reviewed that received services longer than 60 days. (# 1, 2, 3, 4, 6, 7, and 8)</p>	G 145	1. Deficiency is being corrected by the addition of more details in summary reports regarding patient clinical status and progress. 2. To ensure that this has been corrected, and to prevent the deficiency from reoccurring the the future, nursing	05/13/2015

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	<p>Findings include</p> <ol style="list-style-type: none"> <li>1. During interview on 4/27/15 at 11:15 AM, employee B, the administrator, indicated the 60 day summaries are on the bottom of the next 485/Plan of Care.</li> <li>2. During interview on 4/27/15 at 12:15 PM, employee B indicated the 60 day summaries are similar unless the patients have changes to report to the physicians.</li> <li>3. Clinical record #1, start of care (SOC) date 4/22/13, contained a Plan of Care (POC) dated 2/8-4/9/15. The section titled "Summary Update" stated, "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</li> <p>The previous POC dated 12/9/14-2/7/15 section titled "Summary Update" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <li>4. Clinical record #2, SOC date 5/23/12, contained a POC dated 2/17-4/18/15. The section titled "Summary Report" stated, "Patient seen and assessed. Patient remains medically stable, with no</li> </ol>		<p>staff has been educated on Summary Report documentation standards. 3. Nursing Supervisor 4. 5/13/15</p>		

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	<p>concerns at this time. Patient and family satisfied with care."</p> <p>The previous POC dated 4/19-6/18/15 section titled "Summary Report" stated, "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>5. Clinical record #3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15. The section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>The previous POC dated 4/15-6/14/15 section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>6. Clinical record # 4, SOC date 5/18/14, contained a POC dated 3/19-5/18/15. The section titled "Condition update" stated "Patient seen and assessed, patient remains medically stable. Patient satisfied with care provided."</p> <p>7. Clinical record #6 SOC date 1/20/14, contained a POC dated 1/18-3/19/15.</p>			

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	<p>The section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>8. Clinical record #7 SOC date TBD [to be determined] contained an initial POC dated 3/20-5/19/15.</p> <p>The next POC was dated 3/20-5/19/15. The section titled "Condition Update" was blank.</p> <p>9. Clinical record #8, SOC date 9/20/13, contained a POC dated 2/13-4/14/15. The section titled "Condition Update" stated "Patient seen and assessed, Patient remains medically stable but fragile. Continues to require assistance with all ADLs [Activities of Daily Living]."</p> <p>10. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the physician. The plan of care is written instructions signed by the physician for the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 5. The</p>				

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G 158 Bldg. 00	<p>manner in which services will be controlled, coordinated, and evaluated by Forte HHC including coordination with other health or social service providers serving the client. ... 19) Any other appropriate or necessary items. ... All personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. A written summary report for each client is sent to the attending physician at least every 60 days."</p> <p>11. 42 CFR Part 494 defines "Summary Report" to mean the "compilation of the pertinent factories of a patient's clinical notes and progress notes that is submitted to the patient's physician."</p> <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. Based on clinical record review, policy</p>	G 158	1. All client records were audited	05/18/2015

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	<p>review, and interview, the agency failed to ensure home health aide (HHA) services were provided as ordered and failed to ensure the physician was notified of missed visits for 5 of 11 records reviewed. (#2, 3, 5, 6, and 7)</p> <p>Findings include:</p> <p>1. During interview on 4/28/15 at 10:10 AM, employee B, the administrator, indicated the agency does not have a policy for notifying the physicians of missed hours or visits, they only keep track of the missed visits in a binder. Employee B indicated the family is allowed to modify the hours.</p> <p>2. Clinical record # 2, start of care date (SOC) 5/23/12, contained a Plan of Care (POC) dated 2/17-4/18/15 with orders for Home Health Aide (HHA) 8-10 hours per day, 3-5 days per week, for a total of 36 hours per week, Approved hours to be allocated as one continuous episode of care or divided into multiple encounters, Family may modify hours to best meet [patient's] needs."</p> <p>A. The record evidenced HHA services were provided on March 9, 10, 12, and 13, 2015 and totaled 32 hours for week 4. The record failed to evidence the physician was notified of the missed visit</p>		<p>5/5/15-5/7/15, and any necessary updated orders related to PA modifications were sent to PCP.</p> <p>2. Client orders state that they may modify their hours in coordination with other services to best meet client needs. Missed visits (family/client modification of hours) will be communicated to MD on a weekly basis. Updated orders will be sent to MD to reflect Medicaid PA modifications as they are received.</p> <p>3. Nursing Supervisor</p> <p>4. 5/18/15</p>		

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	<p>or that the family had adjusted the hours.</p> <p>B. The record evidenced HHA services were provided March 30, 31 April 1, and 2, 2015 and totaled 32 hours for week 7. The record failed to evidence the physician was notified of the missed visit or that the family had adjusted the hours.</p> <p>C. The record evidenced HHA services were provided on April 6, 7, 9, and 10, 2015, and totaled 28 hours for week 8. The record failed to evidence the physician was notified of the missed visit or that the family had adjusted the hours.</p> <p>D. The record evidenced HHA services were provided on April 13, 14, 15, 16, and 17, 2015, and totaled 34 hours for week 9. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>3. Clinical record # 3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15 with orders for HHA 8 hours per day, 5 days a week, for a total of 40 hours per week for 60 days. Family may adjust hours to meet patient's needs.</p> <p>A. The record evidenced HHA services were provided on March 12, 13,</p>				

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	<p>and 14, 2015, and totaled 36 hours for week 5. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>B. The record evidenced HHA services were provided on March 16, 17, 18, and 21, 2015, and totaled 32 hours for week 6. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>4. Clinical record # 5, SOC date "TBD" [to be determined], contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days a week for a total of up to 40 hours per week for 60 days. Family may modify hours to best meet needs of client.</p> <p>A. The record evidenced HHA services were only provided 4 days for week 2. The record evidenced 9 hours per day HHA services were provided on 4/1, 4/3, and 4/5/15, and 8 hours on 4/2/15. The record failed to evidence the physician was notified of missed visits and/or that the agency was over ordered daily hours. The record failed to evidence the family had adjusted the hours</p>			

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	<p>B. The record evidenced HHA services were only provided 4 days for week 4. The record evidenced 8 hours per day HHA services were provided on 4/13, 14, 15, and 17/2015. The record failed to evidence the physician was notified of missed visits or that the family had adjusted the hours.</p> <p>5. Clinical record # 6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15 with orders for HHA 8 hours per day, 7 days per week, for a total of 56 hours per week for 60 days.</p> <p>A. The record evidenced only 6 hours of HHA services were provided on 3/27/15, totaling 56 hours for week 2. The record failed to evidence the physician was notified of the missed hours.</p> <p>B. The record evidenced only 6 hours of HHA services were provided on 4/3/15, and zero hours on 4/4/15, totaling 46 hours for week 3. The record failed to evidence the physician was notified of the missed hours/visit.</p> <p>6. Clinical record # 7, SOC date "TBD," contained a POC dated 3/20-5/19/15 with orders for HHA 4-6 hours per day, 5-7 days per week for a total of up to 36 hours per week for 60 days.</p>			

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	<p>A. The record evidenced only 3 hours of HHA services were provided daily on 3/26, 27, 28, 29, 30, and 31, and only 3 hours of HHA services were provided daily on 4/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2015. The record failed to evidence the physician was notified the hours provided did not meet the ordered daily hours.</p> <p>During interview on 4/27/15 at 2:15 PM, employee B indicated the Pre-Authorization (PA) decreased the amount of hours to 3 hours per day, and the agency did not notify the physician or update the POC because the change was ordered by the PA.</p> <p>7. The agency's policy titled "Compliance &amp; Implementation," # 4.5, dated 3/1/14, states, "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p>			

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G 159  Bldg. 00	<p>8. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3.1.14, states, "all personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. ... The health care professional staff of the Forte HHC shall promptly alert the person responsible for the medical component of the client's care to any changes that suggest a need to alter the medical plan of care."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care (POC) certification period dates followed federal date guidelines for 8 of 11 records reviewed (# 1, 2, 3, 4, 5, 6, 7, and 8) and</p>	G 159	<p>1. Charts have been audited for SOC/certification dates. Unable to correct errors which occurred in the past. 2. Staff has been educated on the process of proper documentation for SOC dates and certification periods so</p>	05/15/2015			

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	<p>failed to ensure the POC contained a start of care (SOC) date for 2 of 11 records reviewed (# 5 and 7).</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>During interview on 4/23/15 at 10:50 AM, employee P, the office manager, indicated she creates the POC based on the initial nursing assessments. Employee P indicated she uses date&amp;time.org to create the certification periods because this website is a general 60 day calculator, and they have always done it this way.</li> <li>Clinical record # 1, SOC date 4/22/13, contained a POC dated 2/8-4/9/15, and a previous POC dated 12/9/14-2/7/15 .               <ol style="list-style-type: none"> <li>The previous POC should have been dated 12/9/14-2/6/15.</li> <li>The POC dated 2/8-4/9/15 should have been dated 2/7-4/7/15.</li> </ol> </li> <li>Clinical record #2, SOC date 5/23/12, contained a current POC dated 4/19-6/18/15 , and a previous POC dated 2/17-4/18/15.               <ol style="list-style-type: none"> <li>The previous POC should have been dated 2/17-4/17/15.</li> </ol> </li> </ol>		<p>that going forward, they align.</p> <p>3. Nursing Supervisor 4. 5/15/15</p>	

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	<p>B. The current POC should have been dated 4/18-6/16/15.</p> <p>4. Clinical record # 3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15. This should have been dated 2/13-4/13/15.</p> <p>5. Clinical record #4, SOC date 5/18/14, contained a current POC dated 3/19-5/18/15. This should have been dated 3/19-5/17/15.</p> <p>6. Clinical record # 5, SOC date "TBD" (to be determined), contained a POC dated 3/23-5/22/15. This should have been dated 3/23-5/21/15. The SOC is defined as the first billable visit; Therefore, with a dated POC there would have to be a SOC date.</p> <p>A. The correspondence dated 3/30/15, written by employee B, the administrator, stated, "Received PA [pre-authorization] approval for [patient] ... Discussed SOC. HHA to initiate care on 4/1/15."</p> <p>B. The record failed to evidence the SOC was entered on the 485/POC.</p> <p>7. Clinical record # 6, SOC date 1/20/14, contained a current POC dated 3/20-5/19/15. The initial certification period should have been dated</p>			

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	<p>1/20-3/20/15. The current certification should have been dated 3/21-5/19/15.</p> <p>8. Clinical record # 7, SOC date "TBD," contained a current POC dated 3/20-5/19/15. The SOC is defined as first billable visits so it would be impossible to have a "TBD" date for the SOC.</p> <p>A. The current patient list provided on 4/20/15 stated the "SOC date 2/16/15." The initial POC is dated 1/18-3/19/15. The SOC date cannot be after the POC date.</p> <p>B. The initial POC date should have been 2/16-4/16/15.</p> <p>C. The current POC should have been dated 4/17-6/15/15.</p> <p>9. Clinical record # 8, SOC date 9/20/13, contained a current POC dated 2/13-4/14/15. The current POC should have been dated 2/13-4/13/15.</p> <p>10. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the physician. The plan of care is written instructions signed by the physician for</p>			

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G 170 Bldg. 00	<p>the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 19) Any other appropriate or necessary items."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and policy review, the agency failed to ensure the licensed practical nurse (LPN) provided care as ordered for 1 of 1 clinical records reviewed of patients receiving skilled services. (#1)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care date 4/22/13, contained a plan of care dated 2/8-4/9/15 with orders for skilled nursing to monitor vital signs, assess cardiovascular status, pain and symptom control.</p> <p>A. The Skilled Nursing Notes (SNN) dated 3/10, 3/11, and 3/12/15 failed to evidence the LPN assessed vital signs.</p> <p>B. The SNN dated 3/6/15 failed to evidence the LPN assessed blood pressure and pulse.</p>	G 170	<p>1. LPN to receive face to face education on providing care as ordered, as well as documentation of care provided on 5/18/15. 2. To ensure that this deficiency will not reoccur, the nursing notes will be reviewed daily. 3. Nursing Supervisor 4. 5/18/15</p>	05/18/2015

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G 173 Bldg. 00	<p>C. The SNN dated 3/16, 3/17, and 3/20/15 failed to evidence the LPN assessed pain.</p> <p>2. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the physician. The plan of care is written instructions signed by the physician for the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 19) Any other appropriate or necessary items. All personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review, policy review, and interview, the agency failed</p>	G 173	1. Updated order sent to MD to reflect the modification as made by Medicaid PA in cited instance.	05/22/2015			

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	<p>to ensure the nurse updated the plan of care (POC) to reflect a change in the hours for services for 1 of 11 clinical records reviewed. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7, start of care date "TBD," [to be determined] contained a POC dated 3/20-5/19/15 with orders for HHA 4-6 hours per day, 5-7 days per week for a total of up to 36 hours per week for 60 days.</p> <p>The record evidenced only 3 hours of HHA services were provided daily on 3/26, 27, 28, 29, 30, and 31, and only 3 hours of HHA services were provided daily on 4/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2015.</p> <p>2. During interview on 4/27/15 at 2:15 PM, employee B indicated the Pre-Authorization (PA) decreased the amount of hours to 3 hours per day, and the agency did not notify the physician or update the POC because the change was ordered by the PA.</p> <p>The record failed to evidence the registered nurse updated the plan of care to reflect the change in the PA hours.</p>		<p>2. All patient charts audited on 5/5/15 -5/7/15 for accuracy of hours approved by Medicaid PA. Staff educated to notify MD and obtain updated orders for any PA modifications in the future.</p> <p>3. Nursing Supervisor 4. 5/22/15</p>	

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	<p>3. The agency's policy titled "Compliance &amp; Implementation," # 4.5, dated 3/1/14, states, "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p> <p>4. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3.1.14, states, "all personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. ... The health care professional staff of the Forte HHC shall promptly alert the person responsible for the medical component of the client's care to any changes that suggest a need to alter the medical plan of care."</p>				

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G 202  Bldg. 00	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on clinical record review, and interview, it was determined the agency failed to ensure the registered nurse provided clearly written home health aide (HHA) and respite HHA (RHHA) assignments for 3 of 3 records reviewed receiving HHA and RHHA services (see G 224) and failed to ensure the HHA provided care as ordered for 4 of 7 clinical records reviewed receiving HHA services (see G 225).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide Services.</p>			G 202	<p>1. Respite Home Health Aide Service Plans were audited and corrected. Respite Home Health Aide services were promptly separated from PSA binder and placed into Home Health binder. Updated RHHA orders were obtained for clients receiving RHHA services. Nursing Plan of Care updated to include RHHA services for clients who receive both services. Staff educated on following POC. 2. Staff was educated immediately on proper documentation of tasks during the service which they occur (PA or RHHA). Respite bathing to occur if bathing was not completed on PA time, or if patient becomes soiled and requires a second bath. Staff who is responsible for daily note review educated on ensuring that aides are following POC and instructed to notify supervising nurse to report any deviation from POC. 3. Nursing Supervisor4. 5/25/15</p>		05/25/2015
G 224  Bldg. 00	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>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 clinical record review and</p>			G 224	<p>1. Respite Home Health Aide Service Plans were audited and</p>		05/25/2015

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	<p>interview, the agency failed to ensure the registered nurse provided clearly written home health aide (HHA) and respite HHA (RHHA) assignments for 3 of 3 records reviewed of patients receiving HHA and RHHA services. (# 4, 5, and 6)</p> <p>Findings include</p> <p>1. Clinical record # 4, start of care date (SOC) 5/18/14, contained a Plan of Care (POC) dated 3/19-5/18/15 with orders for HHA 2 hours per day, 5 days a week, for 60 days. HHA for bath of patient/family choice as needed, hair wash and comb as patient allows, assist with toileting/brief change as needed, oral care assist as needed, assist with meals or snacks as needed, vital signs: blood pressure, pulse, respirations, temp as needed, ambulation assist as required, assist to chair as needed, range of motion exercises assist as needed, monitor for safety. The section titled "Additional Services" stated "[patient] also received 20 hours per month of respite home health aide services and 6 hours per week of homemaker services through the Aged and Disabled Waiver."</p> <p>A. The Nursing Plan of Care dated 4/2/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge)</p>		<p>corrected. Respite Home Health Aide services were promptly separated from PSA binder and placed into Home Health binder. Updated RHHA orders were obtained for clients receiving RHHA services. Nursing Plan of Care updated to include RHHA services. Staff educated on following POC. 2. Staff was educated immediately on proper documentation of tasks during the service which they occurred (PA or RHHA). Respite bathing to occur if bathing was not completed on PA time, or if patient becomes soiled and requires a second bath. Staff responsible for daily note review educated on ensuring that aides are following POC and instructed to notify supervising nurse to report any deviation from POC. 3. Nursing Supervisor 4. 5/25/15</p>				

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	<p>of patient/family choice of above, if patient agreeable; Hair- Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-Brush teeth -assist as needed; Vital Signs- Blood Pressure, Pulse, Respirations, Temp, as needed; assist with meals or snacks if mealtime; Ambulate, assist as needed; assist to chair as needed; range of motion assist as needed; Other (list)-monitor for safety."</p> <p>B. The Respite HHA Service Plan dated 4/2/15 evidenced the following same tasks assigned on Monday, Wednesday, Thursday, and Saturdays: Bathing assistance, Toileting assistance, and Hair care.</p> <p>C. The record evidenced the HHA and the RHHA both provided bathing to patient #4 on 3/19, 23, 25, 26, and 30, 4/1, 2, 6, 8, 9, 13, 15, and 16, 2015.</p> <p>D. During interview on 4/24/15 at 11:45 AM, employee G, a HHA, indicated she provides the HHA, RHHA, and PSA services for patient #4. Employee G indicated she provides the patient's shower in the mornings after breakfast during HHA hours. At noon, during RHHA hours, she provides snack, makes the bed and does laundry and etcetera. Employee G indicated she fills out the bathing on both the HHA and</p>			

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	<p>RHHA charting but the patient does only receive one shower each day. Employee G indicated she fills in the bathing task on both because she felt it had to be filled in because it was assigned on both services' nursing/aide care plans.</p> <p>E. During interview on 4/24/15 at 12:20 PM, employee N, a registered nurse, indicated she believes the patient requested the RHHA and PSA services, and according to the Notice of Action for the Aged and Disabled Waiver, it is allowable for tasks to be dually assigned and this gives the patient the option of when they want those tasks provided.</p> <p>F. The PSA Notice of Action Supplemental Information for Providers dated 5/1/15-4/30/16 stated, "Respite-HM Health Aide: Respite HHA through Forte Home Health; please provide 2 hours M, W, Th, Sa hours of respite care monthly to ct, per family's request and discretion of time and day. Please assist ct with bathing, dressing, grooming, meals, med reminders, and overall personal care during this time."</p> <p>G. During interview on 4/24/15 at 10:40 AM, employee B, the administrator, indicated the agency keeps the PSA charts separate but it is noted on the Home Health POC that the patient</p>			

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	<p>receives RHHA services.</p> <p>H. During interview on 4/24/15 at 12:45 PM, employee B indicated the RHHA service plan is through Waiver services and that is why it is in the PSA chart.</p> <p>I. During interview on 4/24/15 at 12:55 PM, employee B indicated employee G should be documenting tasks under the service care being provided (HHA, or RHHA).</p> <p>2. Clinical record # 5, SOC date "TBD" (to be determined), contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days per week, for a total of up to 40 hours per week, for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting/brief changing as needed, oral care- assist as needed, assist with meals or snacks as needed, take vital signs - blood pressure, pulse, respirations, temp as needed, ambulation assist as required, assist to chair as needed, range of motion exercise assist as needed, and monitor for safety and falls.</p> <p>A. The Nursing Plan of Care dated 3/25/15 stated, "Home Health Aide Tasks to be Performed (complete only checked</p>			

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	<p>items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting/brief change as needed; Oral Care-assist as needed; Assist with meals or snack as needed, cut food into bites; Vital Signs- Blood Pressure, Pulse, Respirations, Temperature, as needed; Ambulation, assist as required; Assist to chair as needed; Range of motion, assist as needed; Monitor for safety and falls."</p> <p>B. The RHHA service plan dated 3/24/15 evidenced the following same tasks assigned on Sundays and Saturdays: Bathing assistance, toileting assistance, and hair care.</p> <p>3. Clinical record #6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15, with orders for HHA 8 hours a day, 7 days a week for a total of 56 hours per week for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting as needed, oral care- assist with oral care as needed, assist with meals or snacks as needed, take vital signs: Blood Pressure, Pulse, Respirations, temp as needed, Ambulation, provide stand by assist as required, assist to chair as needed, range of motion exercises assist as needed, and monitor for safety, falls</p>			

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G 225  Bldg. 00	<p>and choking. The section titled "Additional Services" states, "[patient] receives 60 hours per month through A&amp;D Waiver."</p> <p>A. The Nursing Plan of Care dated 3/22/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-Brush teeth (assist as needed); Assist with meals or snacks if mealtime; Vital Signs-Blood Pressure, Pulse, Respirations, Oximetry (circle), Temp as needed; ambulate (provide stand by assist as required); Assist to chair (as needed); Range of motion (assist as needed); Other (list) Monitor for safety, falls, and choking."</p> <p>B. The RHHA service plan dated October 1, 2014 evidenced the following same tasks assigned Sunday through Saturday: Bathing assistance, toileting assistance, and hair care.</p> <p>484.36(c)(2) ASSIGNMENT &amp; 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</p>			

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	<p>perform under state law.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the home health aides (HHA) provided care as ordered for 4 of 7 clinical records reviewed receiving HHA services. (# 3, 5, 6, and 7)</p> <p>Findings include</p> <p>1. Clinical record #3, start of care date (SOC) 3/8/12, contained a plan of care (POC) dated 2/13-4/14/15 with orders for HHA 8 hours per day, 5 days a week for a total of 40 hours per week for 60 days. HHA to provide: bath of patient/family choice, hair wash and comb as patient allows, oral care- brush teeth as patient allows, take vital signs as needed, assist with meals or snack if requested, assist to chair as needed, range of motion (ROM) exercises- passive as needed, monitor for seizures and report to family, and monitor for safety.</p> <p>A. The Nursing Plan of Care dated 4/9/15 stated "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable, as needed; Hair- Wash, comb if patient agreeable, as needed; Oral Care-Brush teeth as needed; Vital Signs- Blood Pressure, Pulse,</p>	G 225	<p>1. Home Health Aides educated on following POC. 2. Education completed with all Home Health Aides on following POC. Education completed with staff who is responsible for aides' daily note review, to ensure that aides are following POC for each client. 3. Nursing Supervisor</p> <p>4. 5/25/15</p>	05/25/2015

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	<p>Respirations, Temp, as needed; Assist to Chair, as needed; Range of Motion-Passive, as needed; Monitor for seizures and notify family if occur, every visit; and Monitor for incontinence and provide care (peri care) every visit."</p> <p>B. The Required Documentation sheets for the certification period 2/13-4/14/15 failed to evidence the HHA monitored for seizures and provided peri care every visit.</p> <p>C. During interview on 4/23/15 at 2 PM, employee A, the nursing supervisor, indicated if the task is not listed under Activities Addressed, then the HHA did not select the box- and the HHA should be adding the peri care each time they provide it when the patient is incontinent.</p> <p>2. Clinical record # 5, SOC date "TBD" [to be determined], contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days per week, for a total of up to 40 hours per week, for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting/brief changing as needed, oral care - assist as needed, assist with meals or snacks as needed, take vital signs - blood pressure, pulse, respirations, temp as needed, ambulation assist as required,</p>			

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	<p>assist to chair as needed, range of motion exercise assist as needed, and monitor for safety and falls.</p> <p>A. The Nursing Plan of Care dated 3/25/15 stated "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting/brief change as needed; Oral Care-assist as needed; Assist with meals or snack as needed, cut food into bites; Vital Signs- Blood Pressure, Pulse, Respirations, Temperature, as needed; Ambulation, assist as required; Assist to chair as needed; Range of motion, assist as needed; Monitor for safety and falls."</p> <p>B. The Required Documentation sheets dated 4/1, 4/2,, 4/3, and 4/10/15 failed to evidence the HHA provided a bath.</p> <p>3. Clinical record #6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15, with orders for HHA 8 hours a day, 7 days a week for a total of 56 hours per week for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting as needed, oral care- assist with oral care as needed, assist with meals or</p>			

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	<p>snacks as needed, take vital signs: Blood Pressure, Pulse, Respirations, temp as needed, Ambulation, provide stand by assist as required, assist to chair as needed, range of motion exercises assist as needed, and monitor for safety, falls and choking.</p> <p>A. The Nursing Plan of Care dated 3/22/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-Brush teeth (assist as needed); Assist with meals or snacks if mealtime; Vital Signs-Blood Pressure, Pulse, Respirations, Oximetry (circle), Temp as needed; ambulate (provide stand by assist as required); Assist to chair (as needed); Range of motion (assist as needed); Other (list) Monitor for safety, falls, and choking."</p> <p>B. The Required Documentation sheet dated 4/3/15 failed to evidence a bath was provided.</p> <p>4. Clinical record # 7, SOC date "TBD," contained a POC dated 3/20-5/19/15 with orders for HHA 4-6 hours per day, 5-7 days per week, for a total of up to 36 hours per week, for 60 days. HHA to</p>			

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	<p>provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting as needed, oral care-assist as needed, assist with meals or snacks as needed, take vital signs - blood pressure, pulse, respirations, temp as needed, ambulation assist as required, assist to chair as needed, range of motion exercises assist as needed, and monitor for safety and fall prevention.</p> <p>A. The Nursing Plan of Care dated 3/29/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-brush teeth as needed; Assist with meals or snacks if meal time as needed; Vital Signs- Blood Pressure, Pulse, Respirations, Temperature, as needed; Ambulation, assist as needed; Assist to chair as needed; Range of motion, assist as needed; Monitor for safety."</p> <p>B. The Required Documentation sheets dated 3/26 and 27, 3/29 and 30, 4/1, 2, 3, 4, 5, 7, 9, 10, 11, 12, 14, 16, 17, and 20, 2015 failed to evidence the HHA provided a bath.</p> <p>C. The Required Documentation</p>			

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G 235 Bldg. 00	<p>sheets for HHA visits provided for the certification period from 3/26 through 4/20/15 failed to evidence the HHA monitored for safety and provided ROM.</p> <p>5. The agency's policy titled "Documentation Rules for PSA/Home Health Aide Daily Notes on InCare," no number, dated 5/27/14, states, "The documentation rules in this policy must be followed exactly, without exception. ... 4) At least one option in the Activities Addressed section must be checked. This section reflects what the staff did to assist the client during the shift. Home Health must follow the plan of care located in the client binder. ... 7) In the Caregiver Notes section any activities for that day should be noted."</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the home health charts contained all home health related documents for 3 of 3 records reviewed of patients receiving home health aide, respite HHA, and personal services attendant care services, failed to</p>	G 235	1. Charts audited to ensure that home health charts contain all home health related documents. Respite Home Health Services moved from PSA file to Home Health file. Staff educated on discharge summary report. Instructed staff that discharge summary report to include more details on patient clinical status	05/25/2015

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G 236 Bldg. 00	<p>ensure a discharge summary was maintained in the clinical record, and failed to ensure the physician was notified a discharge summary was available for 3 of 3 discharge records reviewed (see G 236).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.</p> <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, policy review, and interview, the agency failed to ensure the home health charts contained all home health related documents for 3 of 3 records reviewed of patients receiving home health aide (HHA), respite HHA (RHHA), and</p>	G 236	<p>and progress. 2. Respite Home Health documents to be contained in home health chart in the future. Staff educated that MD is to be notified, with each discharge, that a Discharge Summary Report is available. Discharge order modified to reflect this change.</p> <p>3. Administrator 4. 5/25/15</p> <p>1. Charts audited to ensure that home health charts contain all home health related documents. Respite Home Health Services moved from PSA file to Home Health file. Staff educated on discharge summary report. Instructed staff that discharge summary report to include more</p>	05/25/2015

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NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON ST SYRACUSE, IN 46567			
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	<p>personal services attendant (PSA) care services (# 4, 5, and 6); failed to ensure a discharge summary was maintained in the clinical record, and failed to ensure the physician was notified a discharge summary was available for 3 of 3 discharge records reviewed. (# 9, 10, and 11)</p> <p>Findings include</p> <p>1. Clinical record # 4, start of care date (SOC) 5/18/14, contained a Plan of Care (POC) dated 3/19-5/18/15 with orders for HHA 2 hours per day, 5 days a week, for 60 days. The section titled "Additional Services" stated, "[patient] also received 20 hours per month of respite home health aide services and 6 hours per week of homemaker services through the Aged and Disabled Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p> <p>C. The PSA Notice of Action Supplemental Information for Providers dated 5/1/15-4/30/16 stated "Respite-HM Health Aide: Respite HHA through Forte Home Health; please provide 2 hours M [Monday], W [Wednesday], Th</p>		<p>details on patient clinical status and progress. 2. Respite Home Health documents to be contained in home health chart in the future. Staff educated that MD is to be notified, with each discharge, that a Discharge Summary Report is available. Discharge order modified to reflect this change.</p> <p>3. Administrator 4. 5/25/15</p>				

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	<p>[Thursday], Sa [Saturday] hours of respite care monthly to ct [client], per family's request and discretion of time and day. Please assist ct with bathing, dressing, grooming, meals, med reminders, and overall personal care during this time."</p> <p>D. During interview on 4/24/15 at 10:40 AM, employee B, the administrator, indicated the agency keeps the PSA charts separate but it is noted on the Home Health POC that the patient receives RHHA services.</p> <p>E. During interview on 4/24/15 at 12:45 PM, employee B indicated the RHHA service plan is through Waiver services and that is why it is in the PSA chart.</p> <p>F. During interview on 4/24/15 at 12:55 PM, employee B indicated employee G should be documenting tasks under the service care being provided (HHA, or RHHA).</p> <p>2. Clinical record # 5, SOC date "TBD" [to be determined], contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days per week, for a total of up to 40 hours per week, for 60 days. The section titled "Additional Services" stated, "[patient] receives</p>			

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	<p>Attendant Care, Homemaker, and Respite services through the A&amp;D Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p> <p>C. The PSA Notice of Action Supplemental Information for Providers dated 5/1/14-4/30/15 stated "Respite/Forte Home Health/approx [approximately] 10 hours a week or approx 40 hours a month as needed."</p> <p>D. The record failed to evidence the RHHA services were requested/used from 3/23-4/19/15.</p> <p>3. Clinical record #6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15, with orders for HHA 8 hours a day, 7 days a week for a total of 56 hours per week for 60 days. The section titled "Additional Services" stated, "[patient] receives 60 hours per month through A&amp;D Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p>			

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	<p>C. The PSA Notice of Action Supplemental Information for Providers dated 10/1/14-9/30/15 stated "Respite-HM Health Aide, Respite HOHE- to assist the client with personal care. 60 hours a month- 2 hours daily."</p> <p>D. The record failed to evidence the RHHA services were requested/used from 3/20-4/25/15.</p> <p>4. Clinical record #9, SOC 10/20/14, contained a Physician Order Form dated 2/5/15 stating, "Background-Family no longer wishes to use HHA services as family will provide care for [patient]." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>5. Clinical record # 10, SOC date 7/11/14, contained a Physician Order Form dated 3/2/15 stating, "Discharge [patient] from HHC services effective 3/1/15. [Patient] will continue to receive assistance from [PSA agency] through Waiver Services." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>6. Clinical record # 11, SOC date 11/6/14, contained a Physician Order</p>				

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	<p>Form dated 3/10/15 stating, "[Patient] passed away on 3/9/15 at 20:30, while hospitalized at [name of hospital]. Discharge due to death." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>7. During interview on 4/27/15, employee B, the administrator, indicated the discharge summary for patient #9 is in the background section on the order.</p> <p>8. The agency's policy titled "Nursing Plan of Care," # 5.3, dated 3/1/14, states "The nursing plan of care must contain the following: ... 9) The discharge note."</p> <p>9. The agency's policy titled "Compliance &amp; Implementation," # 4.5, dated 3/1/14, states "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p>			

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G 246  Bldg. 00	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. Based on agency document review, policy review, and interview, the agency failed to ensure the Quality Assessment and Performance Improvement (QAPI) program addressed Outcome and Assessment Information Set (OASIS) error reports for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The CASPER Report, (IN) HHA Error Summary by Agency from 10/2014 thru 3/2015 stated, "Error # +262, Error Description: Inconsistent M0090 date: RFA 04 (M0090) does not meet CMS timing guidelines. ... Total # of submitted Assessments Processed: 3. ... % of Submitted Assessments with Field in Error: 66.67%."</p> <p>2. During interview on 4/23/15 at 10:35 AM, employee B, the administrator, indicated the agency only has one skilled patient at this time and the patient has not had any changes of episodes such as hospitalizations or change in condition,</p>			G 246	<p>1. Professional Advisory Committee met on 5/13/15 for quarterly review of Quality Assessment and Performance Improvement program. OASIS error reports were discussed. 2. Any future OASIS error reports will be addressed in QAPI meetings with the Professional Advisory Committee. 3. Nursing Supervisor 4. 5/13/15</p>		05/13/2015

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	<p>so they have only needed to report OASIS every other month.</p> <p>3. During interview on 4/23/15 at 10:50 AM, employee P, the office manager, indicated she creates the POC based on the initial nursing assessments. Employee P indicated she uses date&amp;time.org to create the certification periods because this website is a general 60 day calculator, and they have always done it this way.</p> <p>4. During interview on 4/23/15 at 11 AM, employee B, the administrator, indicated they noticed the warnings showing up when the agency submitted the OASIS for patient #1 but they could not figure out why they were receiving the warnings. Employee A, the nursing supervisor, indicated the agency kept sending the nurse out to do more comprehensive assessments in attempts to correct the error. Employee B indicated this was not discussed in QAPI; she did not think to mention it as it has been going on since before she started.</p> <p>5. Clinical record #1, start of care (SOC) date 4/22/13, contained a plan of care (POC) dated 2/8-4/9/15, and a previous POC dated 12/9/14-2/7/15 .</p> <p>A. The previous POC should have</p>			

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	<p>been dated 12/9/14-2/6/15. The first five day follow up window should have been 2/2-2/6/15. The final validation report dated 2/10/15 evidenced the assessment was completed on 2/5/15, within the window, but only as long as the certification periods prior were dated correctly.</p> <p>B. The POC dated 2/8-4/9/15 should have been dated 2/7-4/7/15. The final validation report dated 4/13/15 evidenced the assessment was completed on 4/9/15.</p> <p>6. The agency's QAPI form dated "Year 2014 4th Quarter" states, "OASIS Transmissions: 2." The QAPI notes failed to address any mention of OASIS error reports, plans to investigate the root cause of errors, and implementation of a performance improvement program.</p> <p>7. The agency's policy titled "Quality Assessment Performance Improvement Plan," no number, dated 1/13/12, states "The Forte Home Health Care, Inc. (Forte HHC) Quality Assessment Performance Improvement Plan (QAPI) ... is designed to capture significant outcomes essential to optimal care. ... Policy ... Forte HHC will focus primarily on its processes and/or system performances ... and will strive to improve operational and client health outcomes by implementing a</p>			

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G 339 Bldg. 00	<p>performance improvement plan that incorporates the following essential processes: ... 2. Monitoring performance through data collection, 3. Analyzing current performance, and 4. Improving and sustaining improved performance over time. ... Forte HHC leaders understand performance improvement principles and methods and ... leaders will be responsible for setting expectations, developing plans and managing processes to improve the Forte HHC's performance."</p> <p>8. The agency's policy titled "Designing Processes/Programs," no number, dated 1/31/12, states "Procedure: 1. Forte HHC leaders will consider the following when identifying potential process/program needs: ... g. OBQM/OBQI reports. ... Utilization Review: ... Data collected will be integrated into the QAPI program to assist Forte HHC in identifying areas needing improvement and in the improvement process. Forte HHC will maintain a written record of the quarterly utilization review process with appropriate signatures."</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p>			

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	<p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review, Outcome and Assessment Information Set (OASIS) CASPER report, and interview, the agency failed to ensure the timeline for OASIS assessments was accurate and errors from final validation reports were corrected for 1 of 1 clinical record reviewed receiving skilled services. (# 1)</p> <p>Findings include</p> <p>1. The CASPER Report, (IN) HHA Error Summary by Agency from 10/2014 thru 3/2015 stated, "Error # +262, Error Description: Inconsistent M0090 date: RFA 04 (M0090) does not meet CMS timing guidelines. ... Total # of submitted Assessments Processed: 3. ... % of Submitted Assessments with Field in Error: 66.67%."</p> <p>2. During interview on 4/23/15 at 10:35 AM, employee B, the administrator, indicated the agency only has one skilled patient at this time and the patient has not had any changes of episodes such as</p>	G 339	<p>1. Joyce Elder was consulted via telephone on 5/13/15 regarding OASIS error reports. Ms. Elders recommended discharging patient 1 and readmitting her, to rectify situation of reoccurring OASIS error reports as related to dates. Discussed issue with mother of the patient and patient's PCP. Plan for patient to be discharged on 5/18/15 and re-admitted on 5/19/15. 2. Staff education completed. Going forward, comprehensive assessment to be updated and revised in the last 5 days of every 60 days beginning with the start of care date for each OASIS patient. 3. Nursing Supervisor 4. 5/19/15</p>	05/19/2015

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	<p>hospitalizations or change in condition, so they have only needed to report OASIS every other month.</p> <p>3. During interview on 4/23/15 at 10:50 AM, employee P, the office manager, indicated she creates the POC based on the initial nursing assessments. Employee P indicated she uses date&amp;time.org to create the certification periods because this website is a general 60 day calculator, and they have always done it this way.</p> <p>4. During interview on 4/23/15 at 11 AM, employee B, the administrator, indicated they noticed the warnings showing up when the agency submitted the OASIS for patient #1 but they could not figure out why they were receiving the warnings. Employee A, the nursing supervisor, indicated the agency kept sending the nurse out to do more comprehensive assessments in attempts to correct the error.</p> <p>5. Clinical record #1, start of care (SOC) date 4/22/13, contained a plan of care (POC) dated 2/8-4/9/15, and a previous POC dated 12/9/14-2/7/15 .</p> <p>A. The previous POC should have been dated 12/9/14-2/6/15. The first five day follow up window should have been</p>			

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N 000  Bldg. 00	<p>2/2-2/6/15. The final validation report dated 2/10/15 evidenced the assessment was completed on 2/5/15, within the window, but only as long as the certification periods prior were dated correctly.</p> <p>B. The POC dated 2/8-4/9/15 should have been dated 2/7-4/7/15. The final validation report dated 4/13/15 evidenced the assessment was completed on 4/9/15.</p>	N 000		
	<p>This was a home health state license survey.</p> <p>Survey Dates: April 20-28, 2015.</p> <p>Facility Number: IN0012779</p> <p>Medicaid Number: 201068710A</p> <p>Census Service Type: Skilled: 1 Home Health Aide Only: 61 Personal Care Only: 0 Total: 62</p>			

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N 462 Bldg. 00	<p>Sample: RR w/HV: 4 RR w/o HV: 7 HV w/o RR: 1 Total: 12</p> <p>QA:JE 5/6/15</p> <p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on employee file review, policy review, and interview, the agency failed to ensure all employee physicals were signed by a physician or nurse practitioner (NP) for 1 of 8 employee files reviewed. (Employee D)</p> <p>Findings include</p> <p>1. Employee file D, a home health aide, date of hire 8/30/12, contained a physical</p>	N 462	<p>1. Employee D received a new physical on 5/12/15 2. All employee records were audited and reviewed to ensure that physicals were completed and that licensures are current. 3. Administrator 4. 5/12/15</p>	05/05/2015			

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N 466 Bldg. 00	<p>dated 6/11/12. The form failed to contain a signature of the physician or nurse practitioner (NP ) who performed the assessment.</p> <p>2. During interview on 4/28/15 at 10:20 AM, employee B, the administrator, indicated she noticed this file's physical was not signed, and the physical was performed by the previous NP who used to work there.</p> <p>3. The agency's policy titled "Employee Files Content," # 6.7, dated 3/1/14, states "Forte HHC employee files shall be kept current and include: ... 12) Physical examinations-Each employee who will have direct client contact shall have a physical examination by a physician or nurse practitioner not more than one hundred eighty (180) days before the date that the employee has direct client contact."</p> <p>410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i)</p>			

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NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON ST SYRACUSE, IN 46567
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	<p>must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on employee file review and interview, the agency failed to ensure employee medical information was kept separate from personnel information for 8 of 8 employee files reviewed. (A, C, D, E, F, G, H, and I)</p> <p>Findings include</p> <p>1. Employee file A, Registered Nurse (RN) date of hire (DOH) 9/16/13, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), RN skills assessment and verification, RN license, Driver's license (DL), Auto insurance, cardiopulmonary resuscitation (CPR) card, CPR skills and test, Criminal History consent and results, I-9 form, and equal employment opportunity (EEO-1) form.</p> <p>2. Employee file C, a Home Health Aide (HHA), DOH 8/22/13, failed to evidence the medical information was kept separate from personnel information.</p>	N 466	<p>1. Employee files audited. Staff education completed. Employee medical information has been separated from all other documents. 2. System put into place to maintain employee medical file which is kept independently of other employee documents. 3. Administrator 4. 5/8/15</p>	05/08/2015

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	<p>The file contained: physical and mantoux results, HHA license, CPR card and test, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), HHA Skills Assessment and Training/Observation, HHA competency test, [another agency name] No Transport Agreement, EEO-1 form, I-9 form, Social Security (SS) card copy, and Criminal History consent and results.</p> <p>3. Employee file D, a HHA, DOH 8/30/12, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), DL, CPR skills and training, CPR card, HHA license and certificate, HHA test, HHA Skills Assessment and Training/Observation, Auto Insurance, and Criminal History consent and results.</p> <p>4. Employee file E, personal care attendant, DOH 11/3/14, failed to evidence the medical information was kept separate from personnel</p>			

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	<p>information. The file contained: chest x-ray results, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), [another agency name] Personal Insurance not Required form and No Transport Agreement, EEO-1 form, I-9 form, SS card, Basic Life Support (BLS) skills test, and Criminal History consent and results.</p> <p>5. Employee file F, a HHA, DOH 2/16/15, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), [another agency name] No Transport Agreement, DL, SS card, BLS skills test, HHA license, HHA skills assessment, HHA test, EEO-1 form, I-9 form, SS card, and Criminal History consent and results.</p> <p>6. Employee file G, a HHA, DOH 6/1/14, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results,</p>			

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	<p>Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), [another agency name] No Transport Agreement, DL, BLS skills test, HHA license, HHA skills assessment, HHA test, EEO-1 form, I-9 form, SS card, and Criminal History consent and results.</p> <p>7. Employee file H, a Licensed Practical Nurse (LPN), DOH 8/12/13, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results, Policies &amp; Procedures (Bed Bath, Proper Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), CPR card, DL, SS card, CPR skills form, LPN license, LPN Skills form, Documentation/charting skills checklist, birth certificate, EEO-1 form, I-9 form, and Criminal History consent and results.</p> <p>8. Employee file I, a HHA, DOH 6/1/14, failed to evidence the medical information was kept separate from personnel information. The file contained: physical and mantoux results, Policies &amp; Procedures (Bed Bath, Proper</p>			

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N 470 Bldg. 00	<p>Use of Medical Gloves, Handwashing, Latex Allergies &amp; Medication Assistance, Vital Signs, Hoyer Lift, and Cleaning Medical Supplies), [another agency name] No Transport Agreement, DL, SS card, CPR card, HHA license, HHA skills assessment, HHA test, EEO-1 form, I-9 form, and Criminal History consent and results.</p> <p>9. During interview on 4/28/15 at 9:55 AM, employee B, the administrator, indicated the employee file health information is all kept in one binder for each employee and also contain policies and expiration dates because corporate at [at their separately licensed PSA agency] said it should be kept this way.</p> <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. Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 3 of 4 home visit observations. (# 1, 2, and 3)</p>	N 470	<p>1. Staff re-training and competency testing in process for all direct care staff, to include policies and procedures for handwashing, medical gloves, bathing, and infection control. 2. Agency to complete annual</p>	05/28/2015			

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	<p>Findings include</p> <p>1. During home visit observation on 4/21/15 at 10 AM with patient #1, employee H, a licensed practical nurse (LPN), was observed providing trach care, oral care, and a bed bath.</p> <p>A. Employee H removed the old trach dressing, wiped around the trach, prepared dressing with cream, and applied the new dressing to the trach site. Employee H failed to don clean gloves after removing old dressing and prior to placing clean dressing to trach site.</p> <p>B. Employee H failed to don gloves while performing oral care.</p> <p>C. During the bed bath, employee H failed to perform hand washing or use hand sanitizer after removing patient's pants and prior to donning clean gloves.</p> <p>D. During the bed bath, employee H failed to change the bath water.</p> <p>E. During the bed bath, employee H failed to wash patient's perineum.</p> <p>F. During interview on 4/23/15 at 9:30 AM, employee A, nursing supervisor, indicated once dirty items are disposed of, staff should be washing</p>		<p>training for home health aides, in the area of infection control.</p> <p>3. Nursing Supervisor 4. 5/28/15</p>	

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	<p>hands or using sanitizer prior to donning new gloves and applying anything clean. Employee A indicated she does not know why the LPN failed to wash the patient's perineum.</p> <p>G. During interview on 4/23/15 at 9:31 AM, employee B, the administrator, indicated typically the agency teaches staff to change the bath water after a dirty area has been washed and to ensure warm water.</p> <p>2. During home visit observation on 4/22/15 at 9 AM, employee J, a home health aide (HHA), was observed providing a shower to patient #2. During the shower, employee J washed the patient's buttocks, and then proceeded to wash the patient's perineal area and proceeded to rinse the patient's hair. Employee J failed to obtain a clean wash cloth and change gloves prior to washing the perineal area.</p> <p>During interview on 4/23/15 at 9:32 AM, both employees A and B, indicated patients' should always be washed from front to back.</p> <p>3. During home visit observation on 4/23/15 at 10:30 AM, employee K, a HHA, was observed providing perineal care to patient #3. Employee K failed to</p>			

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	<p>wash hands or use sanitizer in between removing dirty gloves and prior to donning clean gloves.</p> <p>4. During interview on 4/23/15 at 9:33 AM, employee B indicated employees should be washing hands or using sanitizer prior to donning clean gloves, in between glove changes, and when they have completed care.</p> <p>5. The agency's policy titled "Bed Bath Policy and Procedure," no number, dated 5/9/12, states, "12) ... wash her shoulders, back, side, hips and down to the foot and toes. Rinse the soap away and dry the wet areas with a towel. Change the water in the basins. ... 14) Wash the client's genitals quickly to limit his discomfort. ... Wash a woman's labia."</p> <p>6. The agency's policy titled "Handwashing Policy and Procedure," no number, dated 5/18/12, states, "1. Indications for handwashing and hand antisepsis. ... Wash hands ... after removing gloves; before handling an invasive device (regardless of whether or not gloves are used) for patient care; ... if moving from a contaminated body site to a clean body site during patient care."</p> <p>7. The agency's undated policy titled</p>			

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N 472 Bldg. 00	<p>"Proper Use of Medical Gloves," no number, states, "Removing Gloves ... Discard these gloves in the proper receptacle and immediately wash hands thoroughly. Work from clean to dirty."</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on agency document review, policy review, and interview, the agency failed to ensure the Quality Assessment and Performance Improvement (QAPI) program addressed Outcome and Assessment Information Set (OASIS) error reports for 1 of 1 agency.</p> <p>Findings include</p> <p>1. The CASPER Report, (IN) HHA Error Summary by Agency from 10/2014</p>	N 472	<p>1. Professional Advisory Committee met on 5/13/15 for quarterly review of Quality Assessment and Performance Improvement program. OASIS error reports were discussed.</p> <p>2. Any future OASIS error reports will be addressed in QAPI meetings with the Professional Advisory Committee. 3. Nursing Supervisor 4. 5/13/15</p>	05/13/2015

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	<p>thru 3/2015 stated, "Error # +262, Error Description: Inconsistent M0090 date: RFA 04 (M0090) does not meet CMS timing guidelines. ... Total # of submitted Assessments Processed: 3. ... % of Submitted Assessments with Field in Error: 66.67%."</p> <p>2. During interview on 4/23/15 at 10:35 AM, employee B, the administrator, indicated the agency only has one skilled patient at this time and the patient has not had any changes of episodes such as hospitalizations or change in condition, so they have only needed to report OASIS every other month.</p> <p>3. During interview on 4/23/15 at 10:50 AM, employee P, the office manager, indicated she creates the POC based on the initial nursing assessments. Employee P indicated she uses date&amp;time.org to create the certification periods because this website is a general 60 day calculator, and they have always done it this way.</p> <p>4. During interview on 4/23/15 at 11 AM, employee B, the administrator, indicated they noticed the warnings showing up when the agency submitted the OASIS for patient #1 but they could not figure out why they were receiving the warnings. Employee A, the nursing</p>			

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	<p>supervisor, indicated the agency kept sending the nurse out to do more comprehensive assessments in attempts to correct the error. Employee B indicated this was not discussed in QAPI; she did not think to mention it as it has been going on since before she started.</p> <p>5. Clinical record #1, start of care (SOC) date 4/22/13, contained a plan of care (POC) dated 2/8-4/9/15, and a previous POC dated 12/9/14-2/7/15 .</p> <p>A. The previous POC should have been dated 12/9/14-2/6/15. The first five day follow up window should have been 2/2-2/6/15. The final validation report dated 2/10/15 evidenced the assessment was completed on 2/5/15, within the window, but only as long as the certification periods prior were dated correctly.</p> <p>B. The POC dated 2/8-4/9/15 should have been dated 2/7-4/7/15. The final validation report dated 4/13/15 evidenced the assessment was completed on 4/9/15.</p> <p>6. The agency's QAPI form dated "Year 2014 4th Quarter" states, "OASIS Transmissions: 2." The QAPI notes failed to address any mention of OASIS error reports, plans to investigate the root cause of errors, and implementation of a</p>			

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	<p>performance improvement program.</p> <p>7. The agency's policy titled "Quality Assessment Performance Improvement Plan," no number, dated 1/13/12, states "The Forte Home Health Care, Inc. (Forte HHC) Quality Assessment Performance Improvement Plan (QAPI) ... is designed to capture significant outcomes essential to optimal care. ... Policy ... Forte HHC will focus primarily on its processes and/or system performances ... and will strive to improve operational and client health outcomes by implementing a performance improvement plan that incorporates the following essential processes: ... 2. Monitoring performance through data collection, 3. Analyzing current performance, and 4. Improving and sustaining improved performance over time. ... Forte HHC leaders understand performance improvement principles and methods and ... leaders will be responsible for setting expectations, developing plans and managing processes to improve the Forte HHC's performance."</p> <p>8. The agency's policy titled "Designing Processes/Programs," no number, dated 1/31/12, states "Procedure: 1. Forte HHC leaders will consider the following when identifying potential process/program needs: ... g.</p>			

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N 494 Bldg. 00	<p>OBQM/OBQI reports. ... Utilization Review: ... Data collected will be integrated into the QAPI program to assist Forte HHC in identifying areas needing improvement and in the improvement process. Forte HHC will maintain a written record of the quarterly utilization review process with appropriate signatures."</p> <p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure patients received Outcome and Assessment Information Set (OASIS) privacy rights prior to providing care and collecting OASIS information for 1 of 1 qualifying clinical record reviewed. (# 1)</p> <p>Findings include</p>	N 494	<p>1. OASIS Privacy Rights will be provided to current OASIS patient during home visit to occur 5/18/15. 2. OASIS Privacy Rights will be provided to all OASIS patients upon initial assessment. 3. Administrator 4. 5/18/15</p>	05/18/2015

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	<p>1. Clinical record #1, start of care date 4/22/13, contained a plan of care dated 2/8-4/9/15 with orders for skilled nursing 3-13 hours 3-7 days per week for a total of up to 91 hours per week times 60 days. The clinical record failed to evidence the patient had received notice of OASIS privacy rights.</p> <p>2. During home visit observation on 4/21/15 at at 10:00 AM, the home admission packet failed to evidence OASIS privacy rights information.</p> <p>3. During interview on 4/23/15 at 9:23 AM, employee B, the administrator, indicated the agency does not have a separate OASIS privacy statement.</p> <p>4. The agency's policy titled "Client Rights and Responsibilities Notification," # 5.9, dated 3/1/14, states "Forte HHC [Home Health Care] acknowledges that the client has the right to be informed of his or her rights. Forte HHC strives to protect and promote the exercise of these rights and will complete the following: 1) Provide the client with a written notice of the client's rights in advance of furnishing care to the client or during the initial evaluation visit before the initiation of treatment. 2) Maintain documentation showing that it has</p>			

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NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON ST SYRACUSE, IN 46567		
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N 518 Bldg. 00	<p>complied with the requirements of this section."</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on document and policy review, clinical record review, and observation, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 1 of 4 home visit observations. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/22/13, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 4/21/15 at 10 AM, a home visit was conducted to patient #1. The</p>	N 518	<p>1. Agency audit of each home binder to ensure proper, updated Advanced Directives document (July 2013) is in each home. 2. Updated Advanced Directives are given to each client upon admission. 3. Administrator 4. 5/28/15</p>	05/28/2015	

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N 522	<p>patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>2. During interview on 4/23/15 at 9:22 AM, employee A, nursing supervisor, indicated the agency missed getting the updated Advance Directives packet to patient #1.</p> <p>3. The agency's policy titled "Client Rights and Responsibilities Notification," # 5.9, dated 3/1/14, states "Forte HHC [Home Health Care] acknowledges that the client has the right to be informed of his or her rights. Forte HHC strives to protect and promote the exercise of these rights and will complete the following: ... 13) Forte HHC will comply with the requirements of subpart 1 of part 489 of this state and federal regulations relating to maintaining written policies and procedures regarding advance directive and will inform and distribute written information to the client, in advance, concerning its policies on advance directives, including a description of applicable State law."</p> <p>410 IAC 17-13-1(a) Patient Care</p>			

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Bldg. 00	<p>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:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure home health aide (HHA) services were provided as ordered and failed to ensure the physician was notified of missed visits for 5 of 11 records reviewed. (#2, 3, 5, 6, and 7)</p> <p>Findings include:</p> <p>1. During interview on 4/28/15 at 10:10 AM, employee B, the administrator, indicated the agency does not have a policy for notifying the physicians of missed hours or visits, they only keep track of the missed visits in a binder. Employee B indicated the family is allowed to modify the hours.</p> <p>2. Clinical record # 2, start of care date (SOC) 5/23/12, contained a Plan of Care (POC) dated 2/17-4/18/15 with orders for Home Health Aide (HHA) 8-10 hours per day, 3-5 days per week, for a total of 36 hours per week, Approved hours to be allocated as one continuous episode of care or divided into multiple encounters, Family may modify hours to best meet [patient's] needs."</p>	N 522	<p>1. All client records audited on 5/5/15-5/7/15, and any necessary updated orders related to PA modifications were sent to PCP.</p> <p>2. Client orders state that they may modify their hours in coordination with other services to best meet client needs. Missed visits (family/client modification of hours) will be communicated to MD on a weekly basis. Updated orders will be sent to MD to reflect Medicaid PA modifications as they are received.</p> <p>3. Nursing Supervisor 4. 5/18/15</p>	05/18/2015			

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	<p>A. The record evidenced HHA services were provided on March 9, 10, 12, and 13, 2015 and totaled 32 hours for week 4. The record failed to evidence the physician was notified of the missed visit or that the family had adjusted the hours.</p> <p>B. The record evidenced HHA services were provided March 30, 31 April 1, and 2, 2015 and totaled 32 hours for week 7. The record failed to evidence the physician was notified of the missed visit or that the family had adjusted the hours.</p> <p>C. The record evidenced HHA services were provided on April 6, 7, 9, and 10, 2015, and totaled 28 hours for week 8. The record failed to evidence the physician was notified of the missed visit or that the family had adjusted the hours.</p> <p>D. The record evidenced HHA services were provided on April 13, 14, 15, 16, and 17, 2015, and totaled 34 hours for week 9. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>3. Clinical record # 3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15 with orders for HHA 8 hours per day, 5 days a</p>				

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	<p>week, for a total of 40 hours per week for 60 days. Family may adjust hours to meet patient's needs.</p> <p>A. The record evidenced HHA services were provided on March 12, 13, and 14, 2015, and totaled 36 hours for week 5. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>B. The record evidenced HHA services were provided on March 16, 17, 18, and 21, 2015, and totaled 32 hours for week 6. The record failed to evidence the physician was notified of the missed hours or that the family had adjusted the hours.</p> <p>4. Clinical record # 5, SOC date "TBD" [to be determined], contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days a week for a total of up to 40 hours per week for 60 days. Family may modify hours to best meet needs of client.</p> <p>A. The record evidenced HHA services were only provided 4 days for week 2. The record evidenced 9 hours per day HHA services were provided on 4/1, 4/3, and 4/5/15, and 8 hours on 4/2/15. The record failed to evidence the</p>			

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	<p>physician was notified of missed visits and/or that the agency was over ordered daily hours. The record failed to evidence the family had adjusted the hours</p> <p>B. The record evidenced HHA services were only provided 4 days for week 4. The record evidenced 8 hours per day HHA services were provided on 4/13, 14, 15, and 17/2015. The record failed to evidence the physician was notified of missed visits or that the family had adjusted the hours.</p> <p>5. Clinical record # 6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15 with orders for HHA 8 hours per day, 7 days per week, for a total of 56 hours per week for 60 days.</p> <p>A. The record evidenced only 6 hours of HHA services were provided on 3/27/15, totaling 56 hours for week 2. The record failed to evidence the physician was notified of the missed hours.</p> <p>B. The record evidenced only 6 hours of HHA services were provided on 4/3/15, and zero hours on 4/4/15, totaling 46 hours for week 3. The record failed to evidence the physician was notified of the missed hours/visit.</p>			

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	<p>6. Clinical record # 7, SOC date "TBD," contained a POC dated 3/20-5/19/15 with orders for HHA 4-6 hours per day, 5-7 days per week for a total of up to 36 hours per week for 60 days.</p> <p>A. The record evidenced only 3 hours of HHA services were provided daily on 3/26, 27, 28, 29, 30, and 31, and only 3 hours of HHA services were provided daily on 4/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2015. The record failed to evidence the physician was notified the hours provided did not meet the ordered daily hours.</p> <p>During interview on 4/27/15 at 2:15 PM, employee B indicated the Pre-Authorization (PA) decreased the amount of hours to 3 hours per day, and the agency did not notify the physician or update the POC because the change was ordered by the PA.</p> <p>7. The agency's policy titled "Compliance &amp; Implementation," # 4.5, dated 3/1/14, states, "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in</p>			

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N 524 Bldg. 00	<p>compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p> <p>8. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3.1.14, states, "all personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. ... The health care professional staff of the Forte HHC shall promptly alert the person responsible for the medical component of the client's care to any changes that suggest a need to alter the medical plan of care."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p>			

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	<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, policy review, and interview, the agency failed to ensure the plan of care (POC) certification period dates followed federal date guidelines for 8 of 11 records reviewed (# 1, 2, 3, 4, 5, 6, 7, and 8) and failed to ensure the POC contained a start of care (SOC) date for 2 of 11 records reviewed (# 5 and 7).</p> <p>Findings include</p> <p>1. During interview on 4/23/15 at 10:50 AM, employee P, the office manager, indicated she creates the POC based on the initial nursing assessments. Employee P indicated she uses date&amp;time.org to create the certification periods because this website is a general 60 day calculator, and they have always</p>	N 524	<p>1. Charts have been audited for SOC dates. 2. Staff has been educated on the process of proper documentation for SOC dates and certification periods so that going forward,they align. 3. Nursing Supervisor 4. 5/15/15</p>	05/15/2015

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	<p>done it this way.</p> <p>2. Clinical record # 1, SOC date 4/22/13, contained a POC dated 2/8-4/9/15, and a previous POC dated 12/9/14-2/7/15 .</p> <p>A. The previous POC should have been dated 12/9/14-2/6/15.</p> <p>B. The POC dated 2/8-4/9/15 should have been dated 2/7-4/7/15.</p> <p>3. Clinical record #2, SOC date 5/23/12, contained a current POC dated 4/19-6/18/15 , and a previous POC dated 2/17-4/18/15.</p> <p>A. The previous POC should have been dated 2/17-4/17/15.</p> <p>B. The current POC should have been dated 4/18-6/16/15.</p> <p>4. Clinical record # 3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15. This should have been dated 2/13-4/13/15.</p> <p>5. Clinical record #4, SOC date 5/18/14, contained a current POC dated 3/19-5/18/15. This should have been dated 3/19-5/17/15.</p> <p>6. Clinical record # 5, SOC date "TBD"</p>			

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	<p>(to be determined), contained a POC dated 3/23-5/22/15. This should have been dated 3/23-5/21/15. The SOC is defined as the first billable visit; Therefore, with a dated POC there would have to be a SOC date.</p> <p>A. The correspondence dated 3/30/15, written by employee B, the administrator, stated, "Received PA [pre-authorization] approval for [patient] ... Discussed SOC. HHA to initiate care on 4/1/15."</p> <p>B. The record failed to evidence the SOC was entered on the 485/POC.</p> <p>7. Clinical record # 6, SOC date 1/20/14, contained a current POC dated 3/20-5/19/15. The initial certification period should have been dated 1/20-3/20/15. The current certification should have been dated 3/21-5/19/15.</p> <p>8. Clinical record # 7, SOC date "TBD," contained a current POC dated 3/20-5/19/15. The SOC is defined as first billable visits so it would be impossible to have a "TBD" date for the SOC.</p> <p>A. The current patient list provided on 4/20/15 stated the "SOC date 2/16/15." The initial POC is dated 1/18-3/19/15. The SOC date cannot be</p>			

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N 529 Bldg. 00	<p>after the POC date.</p> <p>B. The initial POC date should have been 2/16-4/16/15.</p> <p>C. The current POC should have been dated 4/17-6/15/15.</p> <p>9. Clinical record # 8, SOC date 9/20/13, contained a current POC dated 2/13-4/14/15. The current POC should have been dated 2/13-4/13/15.</p> <p>10. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the physician. The plan of care is written instructions signed by the physician for the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 19) Any other appropriate or necessary items."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist;</p>						

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	<p>at least every two (2) months.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure a 60 day summary was sent to the physician for 7 of 11 clinical records reviewed that received services longer than 60 days. (# 1, 2, 3, 4, 6, 7, and 8)</p> <p>Findings include</p> <p>1. During interview on 4/27/15 at 11:15 AM, employee B, the administrator, indicated the 60 day summaries are on the bottom of the next 485/Plan of Care.</p> <p>2. During interview on 4/27/15 at 12:15 PM, employee B indicated the 60 day summaries are similar unless the patients have changes to report to the physicians.</p> <p>3. Clinical record #1, start of care (SOC) date 4/22/13, contained a Plan of Care (POC) dated 2/8-4/9/15. The section titled "Summary Update" stated, "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>The previous POC dated 12/9/14-2/7/15 section titled "Summary Update" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time.</p>	N 529	<p>1. Deficiency is being corrected by the addition of more details in summary reports regarding patient clinical status and progress. 2. Nursing staff has been educated on Summary Report documentation standards. 3. Nursing Supervisor 4. 5/13/15</p>	05/13/2015			

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	<p>Patient and family satisfied with care."</p> <p>4. Clinical record #2, SOC date 5/23/12, contained a POC dated 2/17-4/18/15. The section titled "Summary Report" stated, "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>The previous POC dated 4/19-6/18/15 section titled "Summary Report" stated, "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>5. Clinical record #3, SOC date 3/8/12, contained a POC dated 2/13-4/14/15. The section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>The previous POC dated 4/15-6/14/15 section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>6. Clinical record # 4, SOC date 5/18/14, contained a POC dated 3/19-5/18/15.</p>			

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	<p>The section titled "Condition update" stated "Patient seen and assessed, patient remains medically stable. Patient satisfied with care provided."</p> <p>7. Clinical record #6 SOC date 1/20/14, contained a POC dated 1/18-3/19/15. The section titled "Summary Report" stated "Patient seen and assessed. Patient remains medically stable, with no concerns at this time. Patient and family satisfied with care."</p> <p>8. Clinical record #7 SOC date TBD [to be determined] contained an initial POC dated 3/20-5/19/15.</p> <p>The next POC was dated 3/20-5/19/15. The section titled "Condition Update" was blank.</p> <p>9. Clinical record #8, SOC date 9/20/13, contained a POC dated 2/13-4/14/15. The section titled "Condition Update" stated "Patient seen and assessed, Patient remains medically stable but fragile. Continues to require assistance with all ADLs [Activities of Daily Living]."</p> <p>10. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the</p>			

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	<p>physician. The plan of care is written instructions signed by the physician for the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 5. The manner in which services will be controlled, coordinated, and evaluated by Forte HHC including coordination with other health or social service providers serving the client. ... 19) Any other appropriate or necessary items. ... All personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. A written summary report for each client is sent to the attending physician at least every 60 days."</p> <p>11. 410 IAC 17-9-28 states, "Summary report means a clinical synopsis of the pertinent factors from the clinical notes regarding a patient requiring a medical plan of care, which is submitted as a report to the physician."</p>						

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N 537 Bldg. 00	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and policy review, the agency failed to ensure the licensed practical nurse (LPN) provided care as ordered for 1 of 1 clinical records reviewed of patients receiving skilled services. (#1)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care date 4/22/13, contained a plan of care dated 2/8-4/9/15 with orders for skilled nursing to monitor vital signs, assess cardiovascular status, pain and symptom control.</p> <p>A. The Skilled Nursing Notes (SNN) dated 3/10, 3/11, and 3/12/15 failed to evidence the LPN assessed vital signs.</p> <p>B. The SNN dated 3/6/15 failed to evidence the LPN assessed blood pressure and pulse.</p>	N 537	<p>1. LPN to receive face to face education on providing care as ordered, as well as documentation of care provided on 5/18/15. 2. To ensure that this deficiency will not reoccur, the nursing notes will be reviewed daily for accuracy and thoroughness. 3. Nursing Supervisor 4. 5/18/15</p>	05/18/2015

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N 542 Bldg. 00	<p>C. The SNN dated 3/16, 3/17, and 3/20/15 failed to evidence the LPN assessed pain.</p> <p>2. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3/1/14, states "A medical plan of care will be developed for each client receiving care and periodically reviewed by the physician. The plan of care is written instructions signed by the physician for the provision of care, services or treatment to be given by a registered nurse, and a home health aide to a client in the client's place of residence. The plan of care shall include: ... 19) Any other appropriate or necessary items. All personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care."</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record review, policy review, and interview, the agency failed to ensure the nurse updated the plan of care (POC) to reflect a change in the</p>	N 542	<p>1. Updated order sent to MD to reflect the modification as made by Medicaid PA in cited instance. 2. All patient charts audited on 5/5/15 - 5/7/15 for accuracy of</p>	05/22/2015			

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	<p>hours for services for 1 of 11 clinical records reviewed. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7, start of care date "TBD," [to be determined] contained a POC dated 3/20-5/19/15 with orders for HHA 4-6 hours per day, 5-7 days per week for a total of up to 36 hours per week for 60 days.</p> <p>The record evidenced only 3 hours of HHA services were provided daily on 3/26, 27, 28, 29, 30, and 31, and only 3 hours of HHA services were provided daily on 4/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2015.</p> <p>2. During interview on 4/27/15 at 2:15 PM, employee B indicated the Pre-Authorization (PA) decreased the amount of hours to 3 hours per day, and the agency did not notify the physician or update the POC because the change was ordered by the PA.</p> <p>The record failed to evidence the registered nurse updated the plan of care to reflect the change in the PA hours.</p> <p>3. The agency's policy titled "Compliance &amp; Implementation," # 4.5,</p>		<p>hours approved by Medicaid PA. Staff educated to notify MD and obtain updated orders for any PA modifications in the future. 3. Nursing Supervisor 4. 5/22/15</p>	

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N 550 Bldg. 00	<p>dated 3/1/14, states, "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p> <p>4. The agency's policy titled "Medical Plan of Care," # 5.1, dated 3.1.14, states, "all personnel furnishing services shall maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of client care does occur. ... The health care professional staff of the Forte HHC shall promptly alert the person responsible for the medical component of the client's care to any changes that suggest a need to alter the medical plan of care."</p> <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</p>			

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	<p>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 clinical record review and interview, the agency failed to ensure the registered nurse provided clearly written home health aide (HHA) and respite HHA (RHHA) assignments for 3 of 3 records reviewed of patients receiving HHA and RHHA services. (# 4, 5, and 6)</p> <p>Findings include</p> <p>1. Clinical record # 4, start of care date (SOC) 5/18/14, contained a Plan of Care (POC) dated 3/19-5/18/15 with orders for HHA 2 hours per day, 5 days a week, for 60 days. HHA for bath of patient/family choice as needed, hair wash and comb as patient allows, assist with toileting/brief change as needed, oral care assist as needed, assist with meals or snacks as needed, vital signs: blood pressure, pulse, respirations, temp as needed, ambulation assist as required, assist to chair as needed, range of motion exercises assist as needed, monitor for safety. The section titled "Additional Services" stated "[patient] also received 20 hours per month of respite home health aide services and 6 hours per week of homemaker services through the Aged</p>	N 550	<p>1. Respite Home Health Aide Service Plans were audited and corrected. Respite Home Health Aide services were promptly separated from PSA binder and placed into Home Health binder. Updated RHHA orders were obtained for clients receiving RHHA services. Nursing Plan of Cares updated to include RHHA services. Staff educated on following POC. 2. Staff was educated immediately on proper documentation of tasks during the service which they occurred (PA or RHHA). Respite bathing to occur if bathing was not completed on PA time, or if patient becomes soiled and requires a second bath. Staff responsible for daily note review educated on ensuring that aides are following POC and instructed to notify supervising nurse to report any deviation from POC. 3. Nursing Supervisor 4. 5/25/15</p>	05/25/2015

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	<p>and Disabled Waiver."</p> <p>A. The Nursing Plan of Care dated 4/2/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair- Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-Brush teeth -assist as needed; Vital Signs- Blood Pressure, Pulse, Respirations, Temp, as needed; assist with meals or snacks if mealtime; Ambulate, assist as needed; assist to chair as needed; range of motion assist as needed; Other (list)-monitor for safety."</p> <p>B. The Respite HHA Service Plan dated 4/2/15 evidenced the following same tasks assigned on Monday, Wednesday, Thursday, and Saturdays: Bathing assistance, Toileting assistance, and Hair care.</p> <p>C. The record evidenced the HHA and the RHHA both provided bathing to patient #4 on 3/19, 23, 25, 26, and 30, 4/1, 2, 6, 8, 9, 13, 15, and 16, 2015.</p> <p>D. During interview on 4/24/15 at 11:45 AM, employee G, a HHA, indicated she provides the HHA, RHHA, and PSA services for patient #4. Employee G indicated she provides the</p>			

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	<p>patient's shower in the mornings after breakfast during HHA hours. At noon, during RHHA hours, she provides snack, makes the bed and does laundry and etcetera. Employee G indicated she fills out the bathing on both the HHA and RHHA charting but the patient does only receive one shower each day. Employee G indicated she fills in the bathing task on both because she felt it had to be filled in because it was assigned on both services' nursing/aide care plans.</p> <p>E. During interview on 4/24/15 at 12:20 PM, employee N, a registered nurse, indicated she believes the patient requested the RHHA and PSA services, and according to the Notice of Action for the Aged and Disabled Waiver, it is allowable for tasks to be dually assigned and this gives the patient the option of when they want those tasks provided.</p> <p>F. The PSA Notice of Action Supplemental Information for Providers dated 5/1/15-4/30/16 stated, "Respite-HM Health Aide: Respite HHA through Forte Home Health; please provide 2 hours M, W, Th, Sa hours of respite care monthly to ct, per family's request and discretion of time and day. Please assist ct with bathing, dressing, grooming, meals, med reminders, and overall personal care during this time."</p>			

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	<p>G. During interview on 4/24/15 at 10:40 AM, employee B, the administrator, indicated the agency keeps the PSA charts separate but it is noted on the Home Health POC that the patient receives RHHA services.</p> <p>H. During interview on 4/24/15 at 12:45 PM, employee B indicated the RHHA service plan is through Waiver services and that is why it is in the PSA chart.</p> <p>I. During interview on 4/24/15 at 12:55 PM, employee B indicated employee G should be documenting tasks under the service care being provided (HHA, or RHHA).</p> <p>2. Clinical record # 5, SOC date "TBD" (to be determined), contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days per week, for a total of up to 40 hours per week, for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting/brief changing as needed, oral care- assist as needed, assist with meals or snacks as needed, take vital signs - blood pressure, pulse, respirations, temp as needed, ambulation assist as required, assist to chair as needed, range of motion</p>			

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	<p>exercise assist as needed, and monitor for safety and falls.</p> <p>A. The Nursing Plan of Care dated 3/25/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting/brief change as needed; Oral Care-assist as needed; Assist with meals or snack as needed, cut food into bites; Vital Signs- Blood Pressure, Pulse, Respirations, Temperature, as needed; Ambulation, assist as required; Assist to chair as needed; Range of motion, assist as needed; Monitor for safety and falls."</p> <p>B. The RHHA service plan dated 3/24/15 evidenced the following same tasks assigned on Sundays and Saturdays: Bathing assistance, toileting assistance, and hair care.</p> <p>3. Clinical record #6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15, with orders for HHA 8 hours a day, 7 days a week for a total of 56 hours per week for 60 days. HHA to provide: Bath of patient/family choice, hair wash and comb as patient allows, assist with toileting as needed, oral care- assist with oral care as needed, assist with meals or</p>						

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	<p>snacks as needed, take vital signs: Blood Pressure, Pulse, Respirations, temp as needed, Ambulation, provide stand by assist as required, assist to chair as needed, range of motion exercises assist as needed, and monitor for safety, falls and choking. The section titled "Additional Services" states, "[patient] receives 60 hours per month through A&amp;D Waiver."</p> <p>A. The Nursing Plan of Care dated 3/22/15 stated, "Home Health Aide Tasks to be Performed (complete only checked items): Bath (tub, shower, bed, sponge) of patient/family choice of above, if patient agreeable; Hair-Wash, comb if patient agreeable; Assist with toileting as needed; Oral Care-Brush teeth (assist as needed); Assist with meals or snacks if mealtime; Vital Signs-Blood Pressure, Pulse, Respirations, Oximetry (circle), Temp as needed; ambulate (provide stand by assist as required); Assist to chair (as needed); Range of motion (assist as needed); Other (list) Monitor for safety, falls, and choking."</p> <p>B. The RHHA service plan dated October 1, 2014 evidenced the following same tasks assigned Sunday through Saturday: Bathing assistance, toileting assistance, and hair care.</p>			

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N 608  Bldg. 00	<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, policy review, and interview, the agency failed to ensure the home health charts contained all home health related documents for 3 of 3 records reviewed of patients receiving home health aide (HHA), respite HHA (RHHA), and personal services attendant (PSA) care services (# 4, 5, and 6); failed to ensure a discharge summary was maintained in the clinical record, and failed to ensure the physician was notified a discharge summary was available for 3 of 3 discharge records reviewed. (# 9, 10, and 11)</p>	N 608	<p>1. Charts audited to ensure that home health charts contain all home health related documents. Respite Home Health Services moved from PSA file to Home Health file. Staff educated on discharge summary report. Instructed staff that discharge summary report to include more details on patient clinical status and progress. 2. Respite Home Health documents to be contained in home health chart in the future. Staff educated that MD is to be notified, with each discharge, that a Discharge Summary Report is available. Discharge order modified to reflect this change. 3. Administrator 4. 5/25/15</p>	05/25/2015			

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NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON ST SYRACUSE, IN 46567
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	<p>Findings include</p> <p>1. Clinical record # 4, start of care date (SOC) 5/18/14, contained a Plan of Care (POC) dated 3/19-5/18/15 with orders for HHA 2 hours per day, 5 days a week, for 60 days. The section titled "Additional Services" stated, "[patient] also received 20 hours per month of respite home health aide services and 6 hours per week of homemaker services through the Aged and Disabled Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p> <p>C. The PSA Notice of Action Supplemental Information for Providers dated 5/1/15-4/30/16 stated "Respite-HM Health Aide: Respite HHA through Forte Home Health; please provide 2 hours M [Monday], W [Wednesday], Th [Thursday], Sa [Saturday] hours of respite care monthly to ct [client], per family's request and discretion of time and day. Please assist ct with bathing, dressing, grooming, meals, med reminders, and overall personal care during this time."</p> <p>D. During interview on 4/24/15 at</p>			

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	<p>10:40 AM, employee B, the administrator, indicated the agency keeps the PSA charts separate but it is noted on the Home Health POC that the patient receives RHHA services.</p> <p>E. During interview on 4/24/15 at 12:45 PM, employee B indicated the RHHA service plan is through Waiver services and that is why it is in the PSA chart.</p> <p>F. During interview on 4/24/15 at 12:55 PM, employee B indicated employee G should be documenting tasks under the service care being provided (HHA, or RHHA).</p> <p>2. Clinical record # 5, SOC date "TBD" [to be determined], contained a POC dated 3/23-5/22/15 with orders for HHA 6-8 hours per day, 5-7 days per week, for a total of up to 40 hours per week, for 60 days. The section titled "Additional Services" stated, "[patient] receives Attendant Care, Homemaker, and Respite services through the A&amp;D Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p>			

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	<p>C. The PSA Notice of Action Supplemental Information for Providers dated 5/1/14-4/30/15 stated "Respite/Forte Home Health/approx [approximately] 10 hours a week or approx 40 hours a month as needed."</p> <p>D. The record failed to evidence the RHHA services were requested/used from 3/23-4/19/15.</p> <p>3. Clinical record #6, SOC date 1/20/14, contained a POC dated 3/20-5/19/15, with orders for HHA 8 hours a day, 7 days a week for a total of 56 hours per week for 60 days. The section titled "Additional Services" stated, "[patient] receives 60 hours per month through A&amp;D Waiver."</p> <p>A. The clinical record failed to evidence a RHHA nursing care plan.</p> <p>B. The PSA record contained the RHHA nursing care plan.</p> <p>C. The PSA Notice of Action Supplemental Information for Providers dated 10/1/14-9/30/15 stated "Respite-HM Health Aide, Respite HOHE- to assist the client with personal care. 60 hours a month- 2 hours daily."</p> <p>D. The record failed to evidence the</p>			

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	<p>RHHA services were requested/used from 3/20-4/25/15.</p> <p>4. Clinical record #9, SOC 10/20/14, contained a Physician Order Form dated 2/5/15 stating, "Background-Family no longer wishes to use HHA services as family will provide care for [patient]." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>5. Clinical record # 10, SOC date 7/11/14, contained a Physician Order Form dated 3/2/15 stating, "Discharge [patient] from HHC services effective 3/1/15. [Patient] will continue to receive assistance from [PSA agency] through Waiver Services." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>6. Clinical record # 11, SOC date 11/6/14, contained a Physician Order Form dated 3/10/15 stating, "[Patient] passed away on 3/9/15 at 20:30, while hospitalized at [name of hospital]. Discharge due to death." The record failed to evidence a discharge summary and that the physician was notified of a discharge summary.</p> <p>7. During interview on 4/27/15,</p>						

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	<p>employee B, the administrator, indicated the discharge summary for patient #9 is in the background section on the order.</p> <p>8. The agency's policy titled "Nursing Plan of Care," # 5.3, dated 3/1/14, states "The nursing plan of care must contain the following: ... 9) The discharge note."</p> <p>9. The agency's policy titled "Compliance &amp; Implementation," # 4.5, dated 3/1/14, states "Services will be provided in compliance with the health care provider's order, plan of care, and needs of the family and client. The nursing supervisor will collaborate with the client and family to ensure that the care needs are met as ordered and in compliance with the plan of care including coordination with other health or social service providers serving the client. Forte HHC will ensure compliance with accepted professional standards and principles."</p>			