

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2011
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NAME OF PROVIDER OR SUPPLIER HOOSIER HOMECARE SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1240 MERIDIAN ST ANDERSON, IN46016
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G0000	<p>This was a federal home health complaint investigation.</p> <p>Complaint # IN 00099048 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Survey Date: December 15, 2011</p> <p>Facility #: 011757</p> <p>Medicaid Vendor #: 200913590</p> <p>Surveyor: Bridget Boston, RN, PHNS Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 22, 2011</p>	G0000		
G0158	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and policy review and interview, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and orders</p>	G0158	<p>1. The Director of Nursing was instructed on current Policy and Procedures, as well as Federal and State Regulations, which describe the necessary components of the Plan of Care.</p>	01/13/2012

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

TITLE

(X6) DATE

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

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	<p>were obtained for all services and treatments provided in 4 of 5 clinical records reviewed. (#'s 2, 3, 4, and 5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On December 15, 2011, at 2:08 PM, the director of nursing indicated that the agency does not write specific orders for aide frequency and duration of the visits, nor does the agency write orders for all the attendant and homemaking services provided to the patient. She stated, "We only write generic home health orders to cover the other services." 2. The policy titled "Plan Of Care" stated, "The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. ... The Plan of Care shall be completed in full to include: ...type, frequency, and duration of all visits / services. ... Instructions to patient / caregiver, as applicable. ... All of the above items must always be addressed on the Plan Of Care." 3. Clinical record # 2 start of care (SOC) 9/26/11 evidenced a plan of care (POC) for the certification period 9/26/11 		<p>The D.O.N. was instructed on the need to develop separate "visit notes" for Attendant and Homemaker services.</p> <p>The D.O.N. was instructed to inservice the Home Health Aide staff on documentation guidelines as well as the importance of following the orders specifically assigned on the Plan of Care.</p> <p>The D.O.N. was instructed to review the process of documenting "Missed Visits" with each Home Health Aide. In addition, a process for reviewing the HHA's are following the Plan of Care will be implemented as part of the Quality Improvement Plan. The D.O.N. will be responsible for implementing these changes.</p> <p>2. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator</p>		

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	<p>through 11/24/11 with orders that states, "HHA [home health aide] to assist pt with ADL / IADLs [activities of daily living] housekeeping, laundry, medication reminders, bathing, dressing, ect. 5 hrs [hours] qd [every day] - 7 days per week." The visit documentation failed to evidence that home health aide services were provided at 5 hours daily, 7 days a week, as ordered for the last 6 weeks of the certification period which began 9/26/11.</p> <p>A. Week 4: 10/16/11 - 10/22/11 - The record evidenced only 2 hours of home health aide services were provided on 10/18/11 and failed to evidence any visits for 10/22/11. The record evidenced attendant care visits were made on 10/17/11, 10/19/11, 10/21/11, and 10/22/11 for a total of 7 hours of attendant care and failed to evidence an order for the attendant care. Five hours of homemaking services were provided on 10/18/11 and 10/22 and the record failed to evidence an order for this service.</p> <p>B. Week 5: 10/23/11 - 10/29/11 - The record evidenced only 4 hours of home health aide services were provided on 10/23/11, 8 hours were provided on 10/25/11, and 7 hours were provided on 10/27/11, 10/28/11, and 10/29/11. The record evidenced attendant care was</p>		<p>will be responsible for educating the Clinicians. 10% of all medical records will be audited by Quality Assurance personel with results reported quarterly to PAC. 3 (A-F)A process will be implemented on a weekly basis following the Home Health Aides submission of their weekly documentation. Just as the process for tracking Medicare frequency is followed, the Scheduling Supervisor will "check off" the patients' scheduled visits with the submitted documentation to ensure that each scheduled visit has been made. Any missing documentation or unmade visit will be reported to the Director of Nursing. Each Home Health Aide will be given specific instruction when provided with a new patient including a Plan of Care that includes a specific service, frequency, and duration. The D.O.N. will inservice the HHA staff on the new visit note forms (a different form for each service type), documentation guidelines, and the procedure for documenting "missed visits". The HHA staff will also be educated that they are not to perform services beyond that which has been ordered by the Physician with "plan of care oversight". All staff will be inserviced on the definitions of the following: Attendant Care, Homemaking Services, Companionship Services, and Home Health Aide Services. All Clinicians</p>		

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	<p>provided on 10/24/11 for 2 hours and failed to evidence an order for the attendant care services.</p> <p>C. Week 6: 10/30/11 - 11/5/11 - The record evidenced 7 hours of home health aide services were provided on 10/30/11, 10/31/11, 11/2/11, 11/3/11, and 11/4/11 which was more than the hours ordered per day on the POC. The record failed to evidence any visits were provided or offered on 11/5/11. The record evidenced attendant care was rendered on 11/1/11 from 4 PM to 6 PM and failed to evidence an order for the attendant care service.</p> <p>D. Week 7: 11/6/11 - 11/12/11 - The record evidenced 7 hours of home health aide services were provided on 11/7/11, 11/8/11, 11/9/11, 11/10/11, and 11/11/11 which exceeded the hours ordered on the POC. The record evidenced attendant care services were rendered on 11/6/11 from 4 - 6 PM and failed to evidence an order for the attendant care service.</p> <p>E. Week 8: 11/13/11 - 11/19/11 - The record evidenced attendant care services were rendered on 11/14/11, 11/17/11, and 11/18/11 from 4 to 6 PM and on 11/16/11 from 5 to 6 PM and failed to evidence an order for the attendant care services rendered.</p>		<p>responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the Clinicians. 10% of all medical records will be audited by Quality Assurance personel with results reported quarterly to PAC. 4 (A-H) A process will be implemented on a weekly basis following the Home Health Aides submission of their weekly documentation. Just as the process for tracking Medicare frequency is followed, the Scheduling Supervisor will "check off" the patients' scheduled visits with the submitted documentation to ensure that each scheduled visit has been made. Any missing documentation or unmade visit will be reported to the Director of Nursing. Each Home Health Aide will be given specific instruction</p>		

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	<p>F. Week 9: 11/20/11 - 11/26/11 - The record evidenced homemaker services were rendered on 11/21/11, 11/22/11, and 11/23/11 from 4 to 6 PM and failed to evidence an order for the homemaker services rendered.</p> <p>4. Clinical record # 3 SOC 9/23/10 evidenced plan of care for the certification periods 9/21/11 through 11/19/11 and 11/20/11 through 1/18/12 with orders that stated, "Home health aid to assist with personal care / ADL's, medication reminder prn and homemaker services 20 hours per month." The POC failed to evidence the frequency and duration of the aide visits.</p> <p>A. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the discipline as "Home Health Aide" and that 1 hour visits were rendered on 10/24/11, 10/25/11, 10/27/11, 10/28/11, and 11/7/11 for assistance with bathing, dressing, and grooming.</p> <p>B. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Attendant" services and that on 10/18 and 10/27/11 only homemaking tasks were completed during 2 hour visits each day. The record failed to evidence an</p>		<p>when provided with a new patient including a Plan of Care that includes a specific service, frequency, and duration. The D.O.N. will inservice the HHA staff on the new visit note forms (a different form for each service type) , documentation guidelines, and the procedure for documenting "missed visits". The HHA staff will also be educated that they are not to perform services beyond that which has been ordered by the Physician with "plan of care oversight". All staff will be inserviced on the definitions of the following: Attendant Care, Homemaking Services, Companionship Services, and Home Health Aide Services. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator</p>		

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	<p>order for the attendant care service.</p> <p>C. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the discipline was for "Attendant" services and that homemaking tasks were completed on 10/20/11, 10/24/11, 10/25/11, 10/28/11, 10/31/11, 11/1/11, 11/3/11, and 11/10/11 during 3 hour visits. The record failed to evidenced an order for the attendant services rendered.</p> <p>D. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Attendant" services and that on 10/21/11, 11/4/11, 11/7/11, 11/8/11, 11/11/11, 11/14/11, 11/15/11, 11/18/11, 11/21/11, 11/22/11, 11/24/11, 11/25/11, 11/28/11, 11/30/11, 12/1/11, 12/2/11, and 12/5/11 the visits were between 2 and 3 hours each and each visit note included documentation that assistance with bathing, grooming, and homemaking tasks were completed. The record failed to evidence an order for the Attendant care services rendered.</p> <p>E. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the visit was for "Attendant" services and on 11/17/11 the visit was for 2 hours, on 12/6/11 and</p>		<p>will be responsible for educating the staff and ensuring that 10% of all medical records are audited for compliance with these regulations. 5 A process will be implemented on a weekly basis following the Home Health Aides submission of their weekly documentation. Just as the process for tracking Medicare frequency is followed, the Scheduling Supervisor will "check off" the patients' scheduled visits with the submitted documentation to ensure that each scheduled visit has been made. Any missing documentation or unmade visit will be reported to the Director of Nursing. Each Home Health Aide will be given specific instruction when provided with a new patient including a Plan of Care that includes a specific service, frequency, and duration. The D.O.N. will inservice the HHA staff on the new visit note forms (a different form for each service type) , documentation guidelines, and the procedure for documenting "missed visits". The HHA staff will also be educated that they are not to perform services beyond that which has been ordered by the Physician with "plan of care oversight". All staff will be inserviced on the definitions of the following: Attendant Care, Homemaking Services, Companionship Services, and Home Health Aide Services. All Clinicians responsible for participating in the</p>		

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	<p>12/8/11 the visits were for 2.5 hours, and on 12/9/11 the visit was 3 hours.</p> <p>F. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and that on 10/18/11, 10/20/11, 11/4/11, 11/7/11, 11/8/11, 11/14/11, 11/15/11, 11/18/11, 11/21/11, 11/22/11, 11/24/11, 11/25/11, 11/28/11, 11/30/11, 12/1/11, and 12/5/11 each of the visits were between 1 to 1.5 hours and documented homemaking tasks were completed. The record failed to evidence an order for the Homemaker services.</p> <p>G. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and that on 10/21/11, 10/31/11, 11/1/11, 11/3/11, 11/9/11, 11/10/11, and 12/2/11, visits were between 1 to 1.5 hours and documented that bathing assistance tasks were completed. The record failed to evidence orders for the Homemaker service.</p> <p>H. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and on 12/6/11, 12/8, and 12/9/11 the visits were</p>		<p>development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the staff and ensuring that 10% of all medical records are audited for compliance with these regulations.</p>				

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	<p>between 1 to 1.5 hours each and the record failed to evidence an order for the homemaker visits.</p> <p>5. Clinical record # 4 SOC 5/23/11 and a plan of care for the certification period 10/8/11 through 12/6/11 with orders that stated,"HHA to assist pt with adl / iadl's, laundry, meals, housekeeping. Aide will assist pt with bathing and personal care. SN [skilled nurse] for supervisory visits and recertifications." The POC (plan of care) failed to evidenced the frequency and duration of the home health aide service that was to be provided.</p> <p>A. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the service as "Homemaker" and documented homemaking services were provided on 10/14/11 for 4 hours, 10/24/11 and 10/26/11 for 6 hours each day, the on 10/28/11 for 5 hours.</p> <p>B. Other documents also titled "Hoosier Homecare Services" identified the service as "home health aide" and that the services were rendered by employee</p> <p>E. The record evidenced visit documentation:</p> <p>1.) Visits on 10/17/11 - documented 6 hours of service that</p>				

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	<p>included a "Tub / sh [shower] bath" and homemaking tasks.</p> <p>2.) Visits on 10/18, 10/31, 11/14/11, 11/15/11, 11/21/11, 11/23/11, 11/28/11, and 12/1/11 documented six hours visits each day and only homemaking tasks were completed.</p> <p>3.) Visits on 11/9/11 and 11/10/11 documented the visits were for 6 hours each day and that no tasks were completed.</p> <p>4.) Visits on 10/21/11, 11/3/11, 11/22/11, and 11/29/11 were documented 5 hours each visit and only homemaking tasks were completed.</p> <p>5.) On 11/7/11 the visit was documented as a 5 hour visit and no tasks were documented as completed.</p> <p>6.) On 11/17/11 the visit was documented as a 4 hour visit and only homemaking tasks were completed.</p> <p>6. Clinical record # 5, SOC 9/7/11, evidenced a plan of care for the certification period 9/7/11 through 10/31/11 and 11/1/11 through 12/30/11 with orders that stated, "HHA to assist patient with bathing, hygiene, grooming, medication reminders, activity, nutrition,</p>				

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	<p>laundry. and light housekeeping as needed 15 hours per week. The POC failed to evidence the frequency and duration of the visits to be provided.</p> <p>The visit documentation failed to evidence the home health aide services were provided at 15 hours per week for the last three weeks of the certification period beginning 9/7/11, beginning with the week of 10/16/11 and for the first 5 weeks of the certification period beginning 11/1/11.</p> <p>1.) Week 7: 10/16/11 - 10/22/11 evidenced 1 attendant care visit was made on 10/19/11 for 3 hours, and on 10/21/11 for 1 and 1/2 hours, completed by employee D with a total of 4.5 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>2.) Week 8: 10/23/11 - 10/29/11 visits evidenced 1 attendant care visit was made on 10/24/11 for 3 hours, completed by employee D, which did not meet the frequency and hours as ordered on the POC.</p> <p>3.) Week 3: 10/30/11 - 10/31/11 failed to evidence any visits were made, which did not meet the frequency and hours as ordered on the POC.</p>				

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	<p>4.) Week 1: 11/1/11 - 11/5/11 - The record failed to evidence any visits were made, which did not meet the frequency and hours as ordered on the POC.</p> <p>5.) Week 2: 11/6/11 - 11/12/11 evidenced only 1 attendant visit was made on 11/9/11 for 2.25 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>6.) Week 3: 11/13/11 - 11/19/11 evidenced 1 visit was made on 11/16/11 for 3 hours, which did not meet the frequency and hours as ordered on the POC.</p> <p>7.) Week 4: 11/20/11 - 11/26/11 evidenced 1 visit was made on 11/23/11 for 3 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>8.) Week 5: 11/27/11 - 12/3/11 evidenced 3 visits, one on 11/30/11 for 3 hours, one on 12/1/11 for 3 hours, and one on 12/2/11 for 1 hour which did not meet the frequency and hours as ordered on the POC.</p>				

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G0159	<p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record and policy review and interview, the agency failed to ensure a plan of care was developed for the same start of care date and certification period that included all pertinent diagnosis and all types of services with the frequency and duration of all the patient services to be provided for 2 of 5 clinical records reviewed. (#s 2 and 5)</p> <p>The findings include:</p> <p>1. Clinical record # 2, start of care (SOC) 9/21/11 evidenced a plan of care (POC) for the certification period 9/21/11 through 11/19/11 with orders that stated, "SN [skilled nurse] two times a week for 1 week, three times a week for 2 weeks, then twice a week for the last 6 weeks of the certification period; home health aide twice a week for 1 week, three times a week for four weeks, then twice a week for 4 weeks; and for physical therapy and occupational therapy to evaluate and</p>	G0159	G159 1-3 Each patient will have one medical record, regardless of payer source, to allow for coordination of services and development of a single plan of care. The HHA staff will also be educated that they are not to perform services beyond that which has been ordered by the Physician with "plan of care oversight". All staff will be inserviced on the definitions of the following: Attendant Care, Homemaking Services, Companionship Services, and Home Health Aide Services. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to	01/13/2012	

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	<p>treat." This record was identified as medical record number "709" and kept as a separate and independent record from the other services provided by the same agency.</p> <p>In another separate clinical record for patient #2 identified by the agency as medical record number "MCD 22" had a SOC 9/26/11 evidenced a POC for the certification period 9/26/11 through 11/24/11 with orders that states, "HHA [home health aide] to assist pt [patient] with ADL / IADLs [activities of daily living] housekeeping, laundry, medication reminders, bathing, dressing, ect. 5 hrs [hours] qd [every day] - 7 days per week."</p> <p>2. Clinical record # 5, SOC 8/25/11, evidenced a plan of care for the certification period of 8/25/11 through 10/23/11 with orders for skilled nursing 1 time during week one of the certification period, twice a week during week 2 and 3 of the certification period, and once a week during week 4 and 5 of the certification period, physical therapy services once during week one, and twice a week during week 2, 3, and 4 of the certification period, and home health aide services once a week during week one, and twice a week during weeks 2 through 9 of the certification period. This record was identified as medical record number</p>		<p>treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the staff and ensuring that 10% of all medical records are audited for compliance with these regulations. 4. The Director of Nursing was instructed on current Policy and Procedures, as well as Federal and State Regulations, which describe the necessary components of the Plan of Care. The D.O.N. was instructed on the need to develop separate "visit notes" for Attendant and Homemaker services. The D.O.N. was instructed to inservice the Home Health Aide staff on documentation guidelines as well as the importance of following the orders specifically assigned on the Plan of Care. The D.O.N. was instructed to review the process of documenting "Missed Visits" with each Home Health Aide. In addition, a process for reviewing the HHA's are following the Plan of Care will be implemented as part of the Quality Improvement Plan. Each patient will have one medical record, regardless of payer source, to allow for coordination of services and development of a single plan of care. The D.O.N. will be responsible for implementing these changes. 5. All Clinicians responsible for participating in the</p>		

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	<p>"681" and kept as a separate and independent record from the other services provided by the same agency.</p> <p>A second and separate clinical record was identified by the agency as medical record number "LST 005" for patient #5 with start of care date 9/7/11 evidenced a plan of care for the certification periods 9/7/11 through 10/31/11 and 11/1/11 through 12/30/11 with orders that stated, "HHA to assist patient with bathing, hygiene, grooming, medication reminders, activity, nutrition, laundry. and light housekeeping as needed 15 hours per week." The POC failed to evidence the frequency or duration or the service to be provided.</p> <p>3. On December 15, 2011, at 12:12 PM, the alternate administrator and co-owner of the agency indicted the agency has consistently maintained 2 separate records for every patient that received skilled and non skilled services from more than one payer source and indicated they develop 2 plans of care and treat as 2 separate records.</p> <p>4. On December 15, 2011, at 2:08 PM, the director of nursing indicated the agency does not write specific orders for aide frequency and duration of the visits, nor does the agency write orders for all</p>		<p>development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the staff and ensuring that 10% of all medical records are audited for compliance with these regulations.</p>		

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	<p>the attendant and homemaking services provided to the patient. She stated, "We only write generic home health orders to cover the other services." She further confirmed that when they have patients that receive services under medicare and another payer, that the agency treats as 2 separate records, they write 2 plans of care, the skilled visit notes are from a company called Select Data and that Select Data complies the skilled plan of care and that the home health agency complies the other plan of care and treats each record as separate from the other patient's record.</p> <p>5. The policy titled "Plan Of Care" stated, "The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. ... The Plan of Care shall be completed in full to include: ...type, frequency, and duration of all visits / services. ... Instructions to patient / caregiver, as applicable. ... All of the above items must always be addressed on the Plan Of Care."</p>				

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N0522	<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 and policy review and interview, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and orders were obtained for all services and treatments provided in 4 of 5 clinical records reviewed. (#'s 2, 3, 4, and 5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On December 15, 2011, at 2:08 PM, the director of nursing indicated that the agency does not write specific orders for aide frequency and duration of the visits, nor does the agency write orders for all the attendant and homemaking services provided to the patient. She stated, "We only write generic home health orders to cover the other services." 2. The policy titled "Plan Of Care" stated, "The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. ... The Plan of Care shall be completed in full to include: 	N0522	<p>1-6 The Director of Nursing was instructed on current Policy and Procedures, as well as Federal and State Regulations, which describe the necessary components of the Plan of Care. The D.O.N. was instructed on the need to develop separate "visit notes" for Attendant and Homemaker services. The D.O.N. was instructed to inservice the Home Health Aide staff on documentation guidelines as well as the importance of following the orders specifically assigned on the Plan of Care. The D.O.N. was instructed to review the process of documenting "Missed Visits" with each Home Health Aide. In addition, a process for reviewing the HHA's are following the Plan of Care will be implemented as part of the Quality Improvement Plan. The Director of Nursing will be responsible for implementing this process. The D.O.N. will be responsible for implementing these changes. The HHA staff will also be educated that they are not to perform services beyond that which has been ordered by the Physician with "plan of care oversight". All staff will be inserviced on the definitions of the following: Attendant Care, Homemaking Services,</p>	01/13/2012	

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	<p>...type, frequency, and duration of all visits / services. ... Instructions to patient / caregiver, as applicable. ... All of the above items must always be addressed on the Plan Of Care."</p> <p>3. Clinical record # 2 start of care (SOC) 9/26/11 evidenced a plan of care (POC) for the certification period 9/26/11 through 11/24/11 with orders that states, "HHA [home health aide] to assist pt with ADL / IADLs [activities of daily living] housekeeping, laundry, medication reminders, bathing, dressing, ect. 5 hrs [hours] qd [every day] - 7 days per week." The visit documentation failed to evidence that home health aide services were provided at 5 hours daily, 7 days a week, as ordered for the last 6 weeks of the certification period which began 9/26/11.</p> <p>A. Week 4: 10/16/11 - 10/22/11 - The record evidenced only 2 hours of home health aide services were provided on 10/18/11 and failed to evidence any visits for 10/22/11. The record evidenced attendant care visits were made on 10/17/11, 10/19/11, 10/21/11, and 10/22/11 for a total of 7 hours of attendant care and failed to evidence an order for the attendant care. Five hours of homemaking services were provided on 10/18/11 and 10/22 and the record failed</p>		<p>Companionship Services, and Home Health Aide Services. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the staff and ensuring that 10% of all medical records are audited for compliance with these regulations. 6. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected</p>		

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	<p>to evidence an order for this service.</p> <p>B. Week 5: 10/23/11 - 10/29/11 - The record evidenced only 4 hours of home health aide services were provided on 10/23/11, 8 hours were provided on 10/25/11, and 7 hours were provided on 10/27/11, 10/28/11, and 10/29/11. The record evidenced attendant care was provided on 10/24/11 for 2 hours and failed to evidence an order for the attendant care services.</p> <p>C. Week 6: 10/30/11 - 11/5/11 - The record evidenced 7 hours of home health aide services were provided on 10/30/11, 10/31/11, 11/2/11, 11/3/11, and 11/4/11 which was more than the hours ordered per day on the POC. The record failed to evidence any visits were provided or offered on 11/5/11. The record evidenced attendant care was rendered on 11/1/11 from 4 PM to 6 PM and failed to evidence an order for the attendant care service.</p> <p>D. Week 7: 11/6/11 - 11/12/11 - The record evidenced 7 hours of home health aide services were provided on 11/7/11, 11/8/11, 11/9/11, 11/10/11, and 11/11/11 which exceeded the hours ordered on the POC. The record evidenced attendant care services were rendered on 11/6/11 from 4 - 6 PM and failed to evidence an order for the attendant care service.</p>		<p>outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. 10% of all medical records will be audited by Quality Assurance personel with results reported quarterly to PAC. The Adminstrator will be responsible for educating the staff.</p>				

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	<p>E. Week 8: 11/13/11 - 11/19/11 - The record evidenced attendant care services were rendered on 11/14/11, 11/17/11, and 11/18/11 from 4 to 6 PM and on 11/16/11 from 5 to 6 PM and failed to evidence an order for the attendant care services rendered.</p> <p>F. Week 9: 11/20/11 - 11/26/11 - The record evidenced homemaker services were rendered on 11/21/11, 11/22/11, and 11/23/11 from 4 to 6 PM and failed to evidence an order for the homemaker services rendered.</p> <p>4. Clinical record # 3 SOC 9/23/10 evidenced plan of care for the certification periods 9/21/11 through 11/19/11 and 11/20/11 through 1/18/12 with orders that stated, "Home health aid to assist with personal care / ADL's, medication reminder prn and homemaker services 20 hours per month." The POC failed to evidence the frequency and duration of the aide visits.</p> <p>A. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the discipline as "Home Health Aide" and that 1 hour visits were rendered on 10/24/11, 10/25/11, 10/27/11, 10/28/11, and 11/7/11 for assistance with bathing, dressing, and</p>				

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	<p>grooming.</p> <p>B. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Attendant" services and that on 10/18 and 10/27/11 only homemaking tasks were completed during 2 hour visits each day. The record failed to evidence an order for the attendant care service.</p> <p>C. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the discipline was for "Attendant" services and that homemaking tasks were completed on 10/20/11, 10/24/11, 10/25/11, 10/28/11, 10/31/11, 11/1/11, 11/3/11, and 11/10/11 during 3 hour visits. The record failed to evidenced an order for the attendant services rendered.</p> <p>D. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Attendant" services and that on 10/21/11, 11/4/11, 11/7/11, 11/8/11, 11/11/11, 11/14/11, 11/15/11, 11/18/11, 11/21/11, 11/22/11, 11/24/11, 11/25/11, 11/28/11, 11/30/11, 12/1/11, 12/2/11, and 12/5/11 the visits were between 2 and 3 hours each and each visit note included documentation that assistance with bathing, grooming, and homemaking</p>				

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	<p>tasks were completed. The record failed to evidence an order for the Attendant care services rendered.</p> <p>E. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the visit was for "Attendant" services and on 11/17/11 the visit was for 2 hours, on 12/6/11 and 12/8/11 the visits were for 2.5 hours, and on 12/9/11 the visit was 3 hours.</p> <p>F. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and that on 10/18/11, 10/20/11, 11/4/11, 11/7/11, 11/8/11, 11/14/11, 11/15/11, 11/18/11, 11/21/11, 11/22/11, 11/24/11, 11/25/11, 11/28/11, 11/30/11, 12/1/11, and 12/5/11 each of the visits were between 1 to 1.5 hours and documented homemaking tasks were completed. The record failed to evidence an order for the Homemaker services.</p> <p>G. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and that on 10/21/11, 10/31/11, 11/1/11, 11/3/11, 11/9/11, 11/10/11, and 12/2/11, visits were between 1 to 1.5 hours and documented that bathing assistance tasks</p>				

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	<p>were completed. The record failed to evidence orders for the Homemaker service.</p> <p>H. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified that the visit was for "Homemaker" services and on 12/6/11, 12/8, and 12/9/11 the visits were between 1 to 1.5 hours each and the record failed to evidence an order for the homemaker visits.</p> <p>5. Clinical record # 4 SOC 5/23/11 and a plan of care for the certification period 10/8/11 through 12/6/11 with orders that stated, "HHA to assist pt with adl / iadl's, laundry, meals, housekeeping. Aide will assist pt with bathing and personal care. SN [skilled nurse] for supervisory visits and recertifications." The POC (plan of care) failed to evidenced the frequency and duration of the home health aide service that was to be provided.</p> <p>A. The clinical record evidenced documents titled "Hoosier Homecare Services" that identified the service as "Homemaker" and documented homemaking services were provided on 10/14/11 for 4 hours, 10/24/11 and 10/26/11 for 6 hours each day, the on 10/28/11 for 5 hours.</p>				

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	<p>B. Other documents also titled "Hoosier Homecare Services" identified the service as "home health aide" and that the services were rendered by employee E. The record evidenced visit documentation:</p> <p>1.) Visits on 10/17/11 - documented 6 hours of service that included a "Tub / sh [shower] bath" and homemaking tasks.</p> <p>2.) Visits on 10/18, 10/31, 11/14/11, 11/15/11, 11/21/11, 11/23/11, 11/28/11, and 12/1/11 documented six hours visits each day and only homemaking tasks were completed.</p> <p>3.) Visits on 11/9/11 and 11/10/11 documented the visits were for 6 hours each day and that no tasks were completed.</p> <p>4.) Visits on 10/21/11, 11/3/11, 11/22/11, and 11/29/11 were documented 5 hours each visit and only homemaking tasks were completed.</p> <p>5.) On 11/7/11 the visit was documented as a 5 hour visit and no tasks were documented as completed.</p> <p>6.) On 11/17/11 the visit was documented as a 4 hour visit and only</p>						

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	<p>homemaking tasks were completed.</p> <p>6. Clinical record # 5, SOC 9/7/11, evidenced a plan of care for the certification period 9/7/11 through 10/31/11 and 11/1/11 through 12/30/11 with orders that stated, "HHA to assist patient with bathing, hygiene, grooming, medication reminders, activity, nutrition, laundry. and light housekeeping as needed 15 hours per week. The POC failed to evidence the frequency and duration of the visits to be provided.</p> <p>The visit documentation failed to evidence the home health aide services were provided at 15 hours per week for the last three weeks of the certification period beginning 9/7/11, beginning with the week of 10/16/11 and for the first 5 weeks of the certification period beginning 11/1/11.</p> <p>1.) Week 7: 10/16/11 - 10/22/11 evidenced 1 attendant care visit was made on 10/19/11 for 3 hours, and on 10/21/11 for 1 and 1/2 hours, completed by employee D with a total of 4.5 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>2.) Week 8: 10/23/11 - 10/29/11 visits evidenced 1 attendant care visit was made on 10/24/11 for 3 hours, completed</p>				

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	<p>by employee D, which did not meet the frequency and hours as ordered on the POC.</p> <p>3.) Week 3: 10/30/11 - 10/31/11 failed to evidence any visits were made, which did not meet the frequency and hours as ordered on the POC.</p> <p>4.) Week 1: 11/1/11 - 11/5/11 - The record failed to evidence any visits were made, which did not meet the frequency and hours as ordered on the POC.</p> <p>5.) Week 2: 11/6/11 - 11/12/11 evidenced only 1 attendant visit was made on 11/9/11 for 2.25 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>6.) Week 3: 11/13/11 - 11/19/11 evidenced 1 visit was made on 11/16/11 for 3 hours, which did not meet the frequency and hours as ordered on the POC.</p> <p>7.) Week 4: 11/20/11 - 11/26/11 evidenced 1 visit was made on 11/23/11 for 3 hours which did not meet the frequency and hours as ordered on the POC.</p> <p>8.) Week 5: 11/27/11 - 12/3/11 evidenced 3 visits, one on 11/30/11 for 3</p>				

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N0524	<p>hours, one on 12/1/11 for 3 hours, and one on 12/2/11 for 1 hour which did not meet the frequency and hours as ordered on the POC.</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure a plan of care was developed for the same start of care date and</p>	N0524	1-3 All patients admitted under care, regardless of payer source, will have one comprehensive medical record and one "all inclusive" Plan of Care.	01/13/2012	

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	<p>certification period that included all pertinent diagnosis and all types of services with the frequency and duration of all the patient services to be provided for 2 of 5 clinical records reviewed. (#s 2 and 5)</p> <p>The findings include:</p> <p>1. Clinical record # 2, start of care (SOC) 9/21/11 evidenced a plan of care (POC) for the certification period 9/21/11 through 11/19/11 with orders that stated, "SN [skilled nurse] two times a week for 1 week, three times a week for 2 weeks, then twice a week for the last 6 weeks of the certification period; home health aide twice a week for 1 week, three times a week for four weeks, then twice a week for 4 weeks; and for physical therapy and occupational therapy to evaluate and treat." This record was identified as medical record number "709" and kept as a separate and independent record from the other services provided by the same agency.</p> <p>In another separate clinical record for patient #2 identified by the agency as medical record number "MCD 22" had a SOC 9/26/11 evidenced a POC for the certification period 9/26/11 through 11/24/11 with orders that states, "HHA [home health aide] to assist pt [patient]</p>		<p>Coordination of all services will be maintained and coordinated with the patient, caregivers, and physician. Any changes to an existing Plan of Care will be amended and the physician will be alerted. The Administrator will be responsible for the oversight of the merging of the separate medical records/Plan of Cares. The Clinical staff responsible for assessing and developing the Plan of Care will be inserviced on this process to ensure compliance. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the Clinicians. A minimum of 10% of all medical records will be audited quarterly to ensure compliance with this regulation.4-5 The Director of</p>		

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	<p>with ADL / IADLs [activities of daily living] housekeeping, laundry, medication reminders, bathing, dressing, ect. 5 hrs [hours] qd [every day] - 7 days per week."</p> <p>2. Clinical record # 5, SOC 8/25/11, evidenced a plan of care for the certification period of 8/25/11 through 10/23/11 with orders for skilled nursing 1 time during week one of the certification period, twice a week during week 2 and 3 of the certification period, and once a week during week 4 and 5 of the certification period, physical therapy services once during week one, and twice a week during week 2, 3, and 4 of the certification period, and home health aide services once a week during week one, and twice a week during weeks 2 through 9 of the certification period. This record was identified as medical record number "681" and kept as a separate and independent record from the other services provided by the same agency.</p> <p>A second and separate clinical record was identified by the agency as medical record number "LST 005" for patient #5 with start of care date 9/7/11 evidenced a plan of care for the certification periods 9/7/11 through 10/31/11 and 11/1/11 through 12/30/11 with orders that stated, "HHA to assist patient with bathing, hygiene, grooming, medication reminders,</p>		<p>Nursing was instructed on current Policy and Procedures, as well as Federal and State Regulations, which describe the necessary components of the Plan of Care. The D.O.N. was instructed on the need to develop separate "visit notes" for Attendant and Homemaker services. The D.O.N. was instructed to inservice the Home Health Aide staff on documentation guidelines as well as the importance of following the orders specifically assigned on the Plan of Care. The D.O.N. was instructed to review the process of documenting "Missed Visits" with each Home Health Aide. In addition, a process for reviewing the HHA's are following the Plan of Care will be implemented as part of the Quality Improvement Plan. The D.O.N. will be responsible for implementing these changes. All Clinicians responsible for participating in the development of the Plan of Care will be inserviced on the definition and necessary components included in the Plan of Care. Specific components to be addressed for each discipline included on the Plan of Care will be: discipline type (SN, PT, OT, ST, HHA, Attendant Care, Homemaking Services), frequency, and duration. Each type of service will include the interventions and expected outcomes (goals). All Clinicians will be instructed to treat the Plan</p>		

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	<p>activity, nutrition, laundry. and light housekeeping as needed 15 hours per week." The POC failed to evidence the frequency or duration of the service to be provided.</p> <p>3. On December 15, 2011, at 12:12 PM, the alternate administrator and co-owner of the agency indicted the agency has consistently maintained 2 separate records for every patient that received skilled and non skilled services from more than one payer source and indicated they develop 2 plans of care and treat as 2 separate records.</p> <p>4. On December 15, 2011, at 2:08 PM, the director of nursing indicated the agency does not write specific orders for aide frequency and duration of the visits, nor does the agency write orders for all the attendant and homemaking services provided to the patient. She stated, "We only write generic home health orders to cover the other services." She further confirmed that when they have patients that receive services under medicare and another payer, that the agency treats as 2 separate records, they write 2 plans of care, the skilled visit notes are from a company called Select Data and that Select Data complies the skilled plan of care and that the home health agency complies the other plan of care and treats</p>		<p>of Care as a "dynamic process" and will be instructed on procedures for amending/supplementing the Plan of Care. The Administrator will be responsible for educating the Clinicians. A minimum of 10% of all medical records will be audited quarterly to ensure compliance with this regulation.</p>		

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	<p>each record as separate from the other patient's record.</p> <p>5. The policy titled "Plan Of Care" stated, "The Plan of Care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. ... The Plan of Care shall be completed in full to include: ...type, frequency, and duration of all visits / services. ... Instructions to patient / caregiver, as applicable. ... All of the above items must always be addressed on the Plan Of Care."</p>				