

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K082	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807
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G000000	<p>This was a federal home health complaint investigation.</p> <p>Complaint #: IN00152489 - Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Survey Dates: July 15 and 16, 2014</p> <p>Facility Number: IN012746</p> <p>Medicaid Number: 201061990A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 24, 2014</p>	G000000		
G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the physician ordered plan of care (POC) was followed for frequency of services for 2 of 3 clinical records reviewed (# 1 and 3) creating the</p>	G000158	<p>The Director of Nursing 7/17/14 the policy on "care Planning" dated 12/2011 410IAC 17-13-1 (a) (1). The Director of Nursing is held mandatory inservices for 7/24/14 and additional meetings will be held 8/7/14, 8/14/14 for all</p>	08/14/2014

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>potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) 3/27/13, contained a POC for the certification period 5/21-7/19/14 with physician orders for skilled nurse (SN) 2 times a day on non-dialysis days, 1 time a day on dialysis days, for a total of 11 hours per week through the certification period, SN to obtain vital signs including O2 sats and fill medication boxes, monitor medication compliance and educate patient on following medication regimen, SN to assist obtaining blood sugars and administer insulin, monitor skin integrity, provide diabetic foot checks, and educate patient on prescribed diet. Home health aide (HHA) 18 hours a week, 6 days a week, 2 hours on Monday, Wednesday and Saturday, 4 hours on Tuesday, Thursday and Friday. An order dated 5/19/14 evidenced an increase in HHA hours by 2 hours a week for a total of 20 hours a week.</p> <p>A. The clinical record failed to evidence the agency provided 20 hours of HHA services the week of 5/25-5/31/14. Minus the 4 hours canceled by the patient on 5/26, the hours for this week were 13.</p>		<p>active skilled nurses to provide education on patient care and following the plan of care and how to appropriately notify all parties involved when care is not provided according to physicians orders. Modification to the plan of care will be sent to the physician by RN or DON. for POC dated 4/29-6/27 Completion date 7/18/14 When visits are not completed, a missed visit will be present in the chart with notification to the physician. The compliance officer will audit 100% of active patient's medical records monthly until 100% are within compliance as evidence by frequencies being followed according to physicians orders. The Director of Nursing will ensure that Corrections are completed and review Charts quarterly thereafter</p>				

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	<p>B. The clinical record failed to evidence the agency provided 20 hours of HHA services the week of 6/15-6/1/14. The hours for this week were 17.</p> <p>C. The clinical record evidenced the week of 7/6-7/12, a total of 23 HHA hours were provided. The clinical record failed to evidence the physician was notified of having gone over hours the week of 7/6-7/12/14, and failed to evidence an order was obtained for an increase of HHA hours.</p> <p>D. The clinical record failed to evidence the physician was notified of not having met the hours ordered except for specific missed visits by patient request.</p> <p>2. Clinical record #3, SOC 12/30/13, contained a POC dated 4/29-6/27/14 with physician orders for SN 2 visits 5 times a week for a total of 10 hours per week through the certification period to obtain vital signs including O2 saturations, fill medication boxes, audit medication compliance, prefill insulin syringes weekly and monitor diabetic status, assess skin integrity, do diabetic foot checks weekly and educate patient on fall safety. HHA 3-4 times a week for a total of 9 hours a week throughout the certification period.</p>			

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	<p>A. The clinical record evidenced the SN visits were each conducted in half hour time frames twice daily, five days a week totaling only 5 hours per week throughout the certification period, with one day (5/6) totaling 1.25 hours.</p> <p>B. The clinical record failed to evidence the physician was notified of not having met the hours ordered.</p> <p>3. During interview on 7/15/14 at 2:50 PM, employee A indicated patient #1 requested 2 hours more each week to be used on Sundays and they must be using them throughout the week instead. Employee A indicated they were not aware of being over hours for the week of 7/7-7/12/14.</p> <p>4. During interview on 7/16/14 at 10:20 AM, employee A indicated the 10 hours a week for patient #3 needs to be changed because the nurses aren't there that long.</p> <p>5. During interview on 7/16/14 at 10:40 AM, employee E indicated the 10 hours a week were written for pre-authorization for patient #3, so they needed to change the orders and reduce the hours or the nurses need to stay longer at their visits to meet the hours.</p>						

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G000159	<p>6. The agency's policy titled "Frequency Plan of Care (485)," not numbered, reviewed 12/14, states, "5. Agency will maintain and follow frequency and plan of care. If there are missed visits, agency will use hours with the same week to comply with 485."</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 physician ordered plan of care (POC) included the correct medication doses for 1 of 3 clinical records reviewed (#2) creating the potential to affect all the agency's patients. Findings include 1. Clinical record #2, start of care (SOC) 10/1/13, contained a POC dated 11/30/13-1/28/14 and 1/29-3/29/14 with physician orders for medications</p>	G000159	The Director of Nursing reviewed on 7/17/14 the policy "Medications" #38 dated 12/2011 Medication Profiles will be updated and sent to physicians on any changes to medications Skilled Nursing will have mandatory meetings on 7/24/14,8/7/14 and 8/14/14 on notifying the RN on changes to medication profiles when client is Resumed to homecare, changes to level of care and new medications ordered after routine doctor's visits A medication list will be requested with each Admission, ROC or change to level of care	08/14/2014

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	<p>including Lasix 20 mg (milligram) twice daily. The Medication Profile reviewed 10/30/13, 11/14/13, and 12/30/13, 1/21/14, 1/28/14, and 3/24/14 evidenced a change on 11/29/13 for the Lasix to 40 mg twice daily. The POCs both failed to include the Lasix dose change to 40 mg twice daily.</p> <p>A. During interview on 7/15/14 at 3:20 PM, employee A indicated patient #2's Lasix dose was at 20 mg twice daily when they started services with the agency, and then it was increased to 40 mg twice daily. Employee A indicated the Lasix dose was not increased more due to the patient has a history of Benign Prostatic Hypertrophy and is currently improving with TED hose and elevating the bilateral lower extremities.</p> <p>B. During interview on 7/16/14 at 11:10 AM, employee A indicated the licensed practical nurse called them to ask if patient #2 should have an increase of Lasix, and at that time they were on 40 mg twice daily, but the physician said no and wanted to try TED hose. Employee A indicated the patient did not like the TED hose so they changed to ace wraps. Employee A indicated they did not document the phone calls concerning the Lasix questions.</p>		<p>The compliance officer will audit 100% of active patient's charts monthly until 100% are within compliance. The Director of Nursing will ensure corrections are completed and review charts quarterly thereafter. The Administrator will be responsible for monitoring these corrective actions to ensure that deficiency is corrected and will not reoccur. Medication Profiles and 485's will reflect updated changes.</p>				

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	<p>C. During an interview on 7/16/14 at 11:10 AM, employee A indicated the office calls the medication fill nurses whenever there are changes in medications and they get a new copy of the most current medication lists to the patient homes then and place them in the patient folders, but the medication fill nurses also look at the POCs sometimes.</p> <p>D. During a phone interview on 7/23/14 at 10:45 AM, physician office RN indicated the Lasix dosage for patient #2 was 40 mg twice daily since November, 2013 and on 7/17/14 was still 40 mg twice daily.</p> <p>2. The agency's policy titled "Physician Orders, Medication Orders," # 38, effective 12/2011, states, "A. The agency will make information readily available and accessible to staff who are responsible for managing patient's medication. B. Agency will implement a standardized method for creating an accurate list of medications at admission/entry, on-going, recertification and transfer/discharge. ... C. At admission, resumption of care, and any time the patient changes service, setting, provider, or level of care and new medication orders are written medication reconciliation should be performed. ... PROCEDURE ... 2. If the medication</p>				

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G000170	<p>list does not match the medications found in the place of residence reconciliation is to be done. Verbal clarification of orders are to be written for all medication variances or per state regulations."</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, policy review, and interview, the agency failed to ensure the nurses followed the plan of care (POC) for 1 of 3 clinical records reviewed (#3) creating the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #3, start of care 12/30/13, contained a POC dated 4/29-6/2714 with physician orders for akilled nurse 2 visits 5 times a week for a total of 10 hours per week through the certification period to obtain vital signs including oxygen saturations, fill medication boxes, audit medication compliance, prefill insulin syringes weekly and monitor diabetic status, assess skin integrity, do diabetic foot checks weekly, and educate patient on</p>	G000170	<p>The Director of Nursing will havemandatory meetings for all Skilled Nursing on 7/24/14 and additional meetings on 8/7/14 and 8/14/14 on following the plan of care. Any changes to the plan of care need to be communicated to the RN or DON in writing. An order will be written to the physician for anychanges to the plan of care. TheDirector of Nursing will complete anorder to request vital signs to betaken atleast once daily. Completed 7/17/14 Thecompliance officer will audit 100% of activeclients charts monthly until 100% of chartsare in compliance. The Director of Nursing will ensure that Corrections are completed and review Charts quarterly thereafter. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	08/14/2014

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	<p>fall safety. Home health aide 3-4 times a week for a total of 9 hours a week throughout the certification period.</p> <p>A. The SN visit notes failed to evidence the nurse obtained vital signs on 6/27/14 at 4:00-4:30 PM, 6/26/14 at 4:30-5:00 PM, 6/25/14 at 5:05-5:35 PM, 6/24/14 at 5:00-5:30 PM, 6/23/14 at 4:30-5:00 PM, 6/20/14 at 4:55-5:05 PM, 6/19/14 at 4:35-5:05 PM, 6/18/14 at 4:00-4:30 PM, 6/17/14 at 4:55-5:05 PM, 6/16/14 at 5:15-5:45 PM, 6/13/14 at 4:30-5:00 PM, 6/12/14 at 4:00-4:30 PM, 6/11/14 at 4:30-5:00 PM, 6/10/14 at 5:15-5:30 PM, 6/9/14 at 5:00-5:30 PM, 6/5/14 at 5:30-6:00 PM, 6/4/14 at 4:30-5:00 PM, 6/3/14 at 5:25-6:00 PM, 6/2/14 at 4:30-5:00 PM, 5/27/14 at 5:35-6:10 PM, 5/21/14 at 5:05-5:35 PM, 5/20/14 at 5:30-6:00 PM, 5/19/14 at 5:30-6:00 PM, 5/14/14 at 4:35-5:05 PM, 5/13/14 at 5:15-5:50 PM, 5/12/14 at 4:00-4:30 PM, 5/7/14 at 4:00-4:40 PM, 5/6/14 at 5:20-6:15 PM, 5/5/14 at 4:00-4:30 PM, and 4/29/14 at 6:00-6:30 PM.</p> <p>B. The clinical record failed to evidence an addendum or request to only take vital signs once daily.</p> <p>C. During interview on 7/16/14 at 10:20 AM, employee A indicated the orders do say the nurse is to take vital</p>			

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N000000	<p>signs each time and the nurses did ask in a meeting if this was necessary to be done with each visit versus once a day, and employee A had told them once a day was okay.</p> <p>2. The agency's policy titled "Frequency and Plan of Care (485)," not numbered, reviewed 12/14, states, "1. The plan of care is developed in consultation with the agency staff and covers all pertinent diagnoses, ... and other appropriate items."</p> <p>This was a state home health complaint investigation.</p> <p>Complaint #: IN00152489 - Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Survey Dates: July 15 and 16, 2014</p> <p>Facility Number: IN012746</p> <p>Medicaid Number: 201061990A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p>	N000000		

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N000522	<p>Quality Review: Joyce Elder, MSN, BSN, RN July 24, 2014</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure the physician ordered plan of care (POC) was followed for frequency of services for 2 of 3 clinical records reviewed (# 1 and 3) creating the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) 3/27/13, contained a POC for the certification period 5/21-7/19/14 with physician orders for skilled nurse (SN) 2 times a day on non-dialysis days, 1 time a day on dialysis days, for a total of 11 hours per week through the certification period, SN to obtain vital signs including O2 sats and fill medication boxes, monitor medication compliance and educate patient on following medication regimen, SN to assist obtaining blood sugars and administer insulin, monitor</p>	N000522	<p>The Director of Nursing 7/17/14 the policy on "care Planning" dated 12/2011 410 IAC 17-13-1 (a) (1). The Director of Nursing is held mandatory inservices for 7/24/14 and additional meetings will be held 8/7/14, 8/14/14 for all active skilled nurses to provide education on patient care and following the plan of care and how to appropriately notify all parties involved when care is not provided according to physicians orders. Modification to the plan of care POC 4/29-6/27 will be sent to the physician by RN or DON. Completion date 7/18/14 The compliance officer will audit 100% of active patient's medical records monthly until 100% are within compliance as evidence by frequencies being followed according to physicians orders.</p> <p>The Director of Nursing will ensure that Corrections are completed and review Charts quarterly thereafter</p>	08/14/2014			

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	<p>skin integrity, provide diabetic foot checks, and educate patient on prescribed diet. Home health aide (HHA) 18 hours a week, 6 days a week, 2 hours on Monday, Wednesday and Saturday, 4 hours on Tuesday, Thursday and Friday. An order dated 5/19/14 evidenced an increase in HHA hours by 2 hours a week for a total of 20 hours a week.</p> <p>A. The clinical record failed to evidence the agency provided 20 hours of HHA services the week of 5/25-5/31/14. Minus the 4 hours canceled by the patient on 5/26, the hours for this week were 13.</p> <p>B. The clinical record failed to evidence the agency provided 20 hours of HHA services the week of 6/15-6/1/14. The hours for this week were 17.</p> <p>C. The clinical record evidenced the week of 7/6-7/12, a total of 23 HHA hours were provided. The clinical record failed to evidence the physician was notified of having gone over hours the week of 7/6-7/12/14, and failed to evidence an order was obtained for an increase of HHA hours.</p> <p>D. The clinical record failed to evidence the physician was notified of not having met the hours ordered except for specific missed visits by patient</p>			

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	<p>request.</p> <p>2. Clinical record #3, SOC 12/30/13, contained a POC dated 4/29-6/27/14 with physician orders for SN 2 visits 5 times a week for a total of 10 hours per week through the certification period to obtain vital signs including O2 saturations, fill medication boxes, audit medication compliance, prefill insulin syringes weekly and monitor diabetic status, assess skin integrity, do diabetic foot checks weekly and educate patient on fall safety. HHA 3-4 times a week for a total of 9 hours a week throughout the certification period.</p> <p>A. The clinical record evidenced the SN visits were each conducted in half hour time frames twice daily, five days a week totaling only 5 hours per week throughout the certification period, with one day (5/6) totaling 1.25 hours.</p> <p>B. The clinical record failed to evidence the physician was notified of not having met the hours ordered.</p> <p>3. During interview on 7/15/14 at 2:50 PM, employee A indicated patient #1 requested 2 hours more each week to be used on Sundays and they must be using them throughout the week instead. Employee A indicated they were not</p>			

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NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807
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N000524	<p>aware of being over hours for the week of 7/7-7/12/14.</p> <p>4. During interview on 7/16/14 at 10:20 AM, employee A indicated the 10 hours a week for patient #3 needs to be changed because the nurses aren't there that long.</p> <p>5. During interview on 7/16/14 at 10:40 AM, employee E indicated the 10 hours a week were written for pre-authorization for patient #3, so they needed to change the orders and reduce the hours or the nurses need to stay longer at their visits to meet the hours.</p> <p>6. The agency's policy titled "Frequency Plan of Care (485)," not numbered, reviewed 12/14, states, "5. Agency will maintain and follow frequency and plan of care. If there are missed visits, agency will use hours with the same week to comply with 485."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical</p>			

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	<p>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 review, policy review, and interview, the agency failed to ensure the physician ordered plan of care (POC) included the correct medication doses for 1 of 3 clinical records reviewed (#2) creating the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #2, start of care (SOC) 10/1/13, contained a POC dated 11/30/13-1/28/14 and 1/29-3/29/14 with physician orders for medications</p>	N000524	The Director of Nursing reviewed on 7/17/14 the policy "Medications" #38 dated 12/2011 Medication Profiles will be updated and sent to physicians on any changes to medications Skilled Nursing will have mandatory meetings on 7/24/14,8/7/14 and 8/14/14 on notifying the RN on changes to medication profiles when client is Resumed to homecare, changes to level of care and new medications ordered after routine doctor's visits A medication list will be requested with each Admission, ROC or change to level of care The compliance	08/14/2014	

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	<p>including Lasix 20 mg (milligram) twice daily. The Medication Profile reviewed 10/30/13, 11/14/13, and 12/30/13, 1/21/14, 1/28/14, and 3/24/14 evidenced a change on 11/29/13 for the Lasix to 40 mg twice daily. The POCs both failed to include the Lasix dose change to 40 mg twice daily.</p> <p>A. During interview on 7/15/14 at 3:20 PM, employee A indicated patient #2's Lasix dose was at 20 mg twice daily when they started services with the agency, and then it was increased to 40 mg twice daily. Employee A indicated the Lasix dose was not increased more due to the patient has a history of Benign Prostatic Hypertrophy and is currently improving with TED hose and elevating the bilateral lower extremities.</p> <p>B. During interview on 7/16/14 at 11:10 AM, employee A indicated the licensed practical nurse called them to ask if patient #2 should have an increase of Lasix, and at that time they were on 40 mg twice daily, but the physician said no and wanted to try TED hose. Employee A indicated the patient did not like the TED hose so they changed to ace wraps. Employee A indicated they did not document the phone calls concerning the Lasix questions.</p>		<p>officer will audit 100% of active patient's charts monthly until 100% are within compliance The Director of Nursing will ensure corrections are completed and review charts quarterly thereafter The Administrator will be responsible for monitoring these corrective actions to ensure that deficiency is corrected and will not reoccur. Medication Profiles and 485's will reflect updated changes</p>				

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	<p>C. During an interview on 7/16/14 at 11:10 AM, employee A indicated the office calls the medication fill nurses whenever there are changes in medications and they get a new copy of the most current medication lists to the patient homes then and place them in the patient folders, but the medication fill nurses also look at the POCs sometimes.</p> <p>D. During a phone interview on 7/23/14 at 10:45 AM, physician office RN indicated the Lasix dosage for patient #2 was 40 mg twice daily since November, 2013 and on 7/17/14 was still 40 mg twice daily.</p> <p>2. The agency's policy titled "Physician Orders, Medication Orders," # 38, effective 12/2011, states, "A. The agency will make information readily available and accessible to staff who are responsible for managing patient's medication. B. Agency will implement a standardized method for creating an accurate list of medications at admission/entry, on-going, recertification and transfer/discharge. ... C. At admission, resumption of care, and any time the patient changes service, setting, provider, or level of care and new medication orders are written medication reconciliation should be performed. ... PROCEDURE ... 2. If the medication</p>			

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N000537	<p>list does not match the medications found in the place of residence reconciliation is to be done. Verbal clarification of orders are to be written for all medication variances or per state regulations."</p> <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, policy review, and interview, the agency failed to ensure the nurses followed the plan of care (POC) for 1 of 3 clinical records reviewed (#3) creating the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #3, start of care 12/30/13, contained a POC dated 4/29-6/27/14 with physician orders for skilled nurse 2 visits 5 times a week for a total of 10 hours per week through the certification period to obtain vital signs including oxygen saturations, fill medication boxes, audit medication compliance, prefill insulin syringes</p>	N000537	<p>The Director of Nursing will have mandatory meetings on 7/24/14 and additional meetings on 8/7/14 and 8/14/14 to all skilled nursing to on provide education on patient care, following plan of care and how to appropriately notify all parties involved when care is not provided according to physicians orders An order will be written to the physician for any changes to the plan of care The Director of Nursing will complete an order to request vital signs to be taken atleast once daily for POC dated 4/29-6/27/14 complete 7/17/14 The Compliance officer will audit 100% of active clients charts monthly until 100% of charts are</p>	08/14/2014

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	<p>weekly and monitor diabetic status, assess skin integrity, do diabetic foot checks weekly, and educate patient on fall safety. Home health aide 3-4 times a week for a total of 9 hours a week throughout the certification period.</p> <p>A. The SN visit notes failed to evidence the nurse obtained vital signs on 6/27/14 at 4:00-4:30 PM, 6/26/14 at 4:30-5:00 PM, 6/25/14 at 5:05-5:35 PM, 6/24/14 at 5:00-5:30 PM, 6/23/14 at 4:30-5:00 PM, 6/20/14 at 4:55-5:05 PM, 6/19/14 at 4:35-5:05 PM, 6/18/14 at 4:00-4:30 PM, 6/17/14 at 4:55-5:05 PM, 6/16/14 at 5:15-5:45 PM, 6/13/14 at 4:30-5:00 PM, 6/12/14 at 4:00-4:30 PM, 6/11/14 at 4:30-5:00 PM, 6/10/14 at 5:15-5:30 PM, 6/9/14 at 5:00-5:30 PM, 6/5/14 at 5:30-6:00 PM, 6/4/14 at 4:30-5:00 PM, 6/3/14 at 5:25-6:00 PM, 6/2/14 at 4:30-5:00 PM, 5/27/14 at 5:35-6:10 PM, 5/21/14 at 5:05-5:35 PM, 5/2014 at 5:30-6:00 PM, 5/19/14 at 5:30-6:00 PM, 5/14/14 at 4:35-5:05 PM, 5/13/14 at 5:15-5:50 PM, 5/12/14 at 4:00-4:30 PM, 5/7/14 at 4:00-4:40 PM, 5/6/14 at 5:20-6:15 PM, 5/5/14 at 4:00-4:30 PM, and 4/29/14 at 6:00-6:30 PM.</p> <p>B. The clinical record failed to evidence an addendum or request to only take vital signs once daily.</p>		<p>in compliance The Director of Nursing will ensure that corrections are completed and review charts quarterly thereafter The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not reoccur</p>		

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	<p>C. During interview on 7/16/14 at 10:20 AM, employee A indicated the orders do say the nurse is to take vital signs each time and the nurses did ask in a meeting if this was necessary to be done with each visit versus once a day, and employee A had told them once a day was okay.</p> <p>2. The agency's policy titled "Frequency and Plan of Care (485)," not numbered, reviewed 12/14, states, "1. The plan of care is developed in consultation with the agency staff and covers all pertinent diagnoses, ... and other appropriate items."</p>				