

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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G000000	<p>This was a federal home health recertification survey. The survey was partial extended and extended survey.</p> <p>Survey Dates: 4-23-13, 4-24-13, 4-25-13, &amp; 4-29-13 Partial extended 4-30-13 &amp; 5-1-13 Extended</p> <p>Facility #: 005940</p> <p>Medicaid Vendor #: 100265610A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 250 skilled, 0 home health aide only, 0 personal services</p> <p>Care One Home Health was found to be out of compliance with Conditions of Participation 42 CFR 484.58 Acceptance of Patients, Plan of Care, and Medical Supervision</p> <p>Care One Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 5-8-13 to 5-8-15 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and</p>	G000000	<p>The submission of this Plan of Correction does not indicate an admission by Care One Home Health that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the patients of Care One Home Health. This Home Health Agency recognized its obligation to provide legally and medically necessary care and services to its patients in an economic and efficient manner. Care One Home Health hereby maintains it is in substantial compliance with the requirements of participation for home health agencies. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this agency. It is thus submitted as a matter of statute only.</p>	
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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>Medical Supervision.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>May 8, 2013</p>			
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G000121	<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. Based on observation, agency policy and clinical record review, document review, and interview, the agency failed to ensure its staff provided services in accordance with its own infection control policies and procedures and the Centers for Disease Control and other infection control documents in 6 (#s 3, 4, 5, 6, 7, and 8) of 8 home visit observations creating the potential for the spread of disease causing organisms among staff and all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Body Substance Precaution" policy # 4014 states, "Agency personnel will adhere to the following precautions . . . Personal Protective Equipment . . . All personnel must use appropriate personal protective equipment . . . Handwashing: Handwashing will be performed to prevent cross-contamination between patients/clients and personnel. Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after patient/client</p>	G000121	<p>Patient identified was immediately transferred to the bathroom and changed clothes prior to the RN leaving the home. DON updated Policy #4107 to clarify between using soap and water vs. hand gel, unless contraindicated for specific organism. All HHA's will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All HHA's will perform a return demonstration for appropriate technique. All staff will be in-serviced by the Administrator or designee related to pets in the home and how to safely work around pets while keeping an appropriate clean barrier in place. All staff will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All staff will perform a return demonstration for appropriate technique. All therapists will be in-serviced by the Therapy Manager or designee related to Universal Precautions and utilizing ultrasound gel. All</p>	05/30/2013			

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	<p>contact, if contaminated with body substances, before and after gloves are worn . . . Gloves: . . . Gloves are to be worn by all agency staff when direct patient contact with any body substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind). Gloves are to be worn when contact with non-intact skin is anticipated. Gloves are to be worn when handling soiled linens."</p> <p>The agency's undated "Handwashing" policy number 4017 states, "Personnel providing care/service in the home setting will wash their hands: . . . Before and after each contact with a patient/client, After handling bed pans, urinals, catheters, linens, before and after gloves are removed."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes,</p>		<p>staff will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All staff will perform a return demonstration for appropriate technique. All staff will be in-serviced by the Administrator or designee related to the CDC's guidelines for safely caring for patients with active C-Dificil.Administrator/DON in-serviced all Clinical Managers on 5.14.13 related to complying with acceptable professional standards and principles of handwashing and Universal Precautions, safely working around pets while keeping an appropriate clean barrier in place and the CDC's guidelines for safely caring for patients with active C-Dificil.Each Clinical Manager assigned to each home health location will ride along with at least one employee per month for three months, utilizing an observation checklist, to ensure compliance with acceptable practices of infection control and Universal Precautions.Each Clinical Manager assigned to each location will also ride along with employee at time of annual evaluation and prior to the employee being released to the field, if newly hired, to ensure compliance.Administrator or designee to monitor for ongoing compliance.The agency's QA</p>				

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	<p>nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 5 on 4-23-13 at 10:05 AM with employee D, a home health aide. The aide was observed to assist the patient with a bath. The aide placed her nursing bag on a barrier on a chair near the patient. The patient's dog was observed</p>		<p>team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>		

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	<p>to jump up into the chair and sniff the nursing bag. The aide was not observed to discourage the dog from sitting the chair or to remove the dog from the chair.</p> <p>A. The patient was seated in a wheelchair throughout the bath procedure. The aide was observed to assist the patient to stand using a walker for assistance. The aide washed and rinsed the front perineal area then the buttocks and rectal area. Without changing her gloves or cleansing her hands, the aide then assisted the patient to sit and rest. While the patient was seated, the aide placed a Depends and pants over the patient's feet in preparation to pull them up when the patient stood. The aide then assisted the patient to stand and pulled the Depends and pants up to the patient's waist.</p> <p>B. After assisting the patient to sit again and while wearing the same gloves, the aide then emptied the bath water into the sink and put away the bath supplies. The aide then removed her gloves and, without cleansing her hands, put away the bowl used to hold the bath water. The aide then retrieved a hairbrush and brushed the patient's hair. The aide then washed her hands.</p> <p>4. A home visit was made to patient 4 on</p>						

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	<p>4-24-13 at 1:05 PM with employee H, a registered nurse (RN). The RN was observed to perform a wound vacuum dressing change to the patient's sternum. After completing the assessment, the RN removed her gloves and cleansed her hands. She removed the patient's shirt and covered the patient's upper body with a towel obtained from the patient's supply. The RN then donned clean gloves without cleansing her hands. The RN removed the suction machine from its bag and disposed of the used canister. She then removed her gloves and, without cleansing her hands, gathered the supplies needed for the dressing change. The RN then donned clean gloves without cleansing her hands and removed the old dressing. The RN removed her gloves and, without cleansing her hands, gathered more supplies from a bag in the patient's home. The RN then cleaned her hands and donned clean gloves.</p> <p>After cutting the black foam and drape pieces to size, the RN cleansed the wound with a normal saline soaked gauze. Without changing her gloves and cleansing her hands, the RN completed the dressing change.</p> <p>5. A home visit was made to patient number 3 on 4-24-13 at 2:45 PM with employee I, a physical therapist. The</p>						

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	<p>therapist was observed to provide an ultrasound treatment to the patient's left knee. After the treatment was completed, the therapist wiped the gel from the patient's knee and changed his gloves without cleansing his hands. The therapist turned the machine off and placed the cords in their proper place. The therapist then massaged the left knee and wiped away the remaining gel. The therapist then removed his gloves and cleansed his hands.</p> <p>6. A home visit was made to patient number 6 on 4-25-13 at 9:00 AM with employee J, a registered nurse. The RN was observed to perform a dressing change to the patient's left ankle. The RN prepared the workspace and supplies and donned clean gloves without cleansing her hands. The RN touched a TV remote and then needed to retrieve some supplies from her car. She removed her gloves and cleansed her hands and retrieved the supplies from her car. She cleansed her hands and placed some gloves and other supplies retrieved from a bag in the patient's home onto the work area. She then cleaned her scissors and donned clean gloves without cleansing her hands. She cleansed the wound with normal saline and dried it with a clean piece of gauze. Without changing her gloves and cleansing her hands, the RN completed</p>			
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	<p>the dressing change.</p> <p>After completing the dressing change, the RN changed her gloves without cleansing her hands. She then cleaned the scissors and gathered the trash for disposal. After disposing of the trash, the RN removed her gloves and cleansed her hands.</p> <p>7. A home visit was made to patient number 7 on 4-29-13 at 9:40 AM with employee K, a registered nurse. The RN was observed to perform a dressing change to the inner aspects of the patient's gluteal folds. The patient stood while the RN changed the dressing. When the RN pulled the patient's pants and underwear down to access the wound, a moderate amount of feces was observed in the patient's underwear and on the dressing. The RN removed the dressing and cleansed the patient's rectal area removing the feces.</p> <p>A. After cleansing the wounds with normal saline soaked gauze, the RN removed her gloves and cleansed her hands. The RN retrieved her scissors and opened packages of gauze obtained from the patient's supply in the home. The RN then donned clean gloves without cleansing her hands. The RN cut the dressing to size and changed her gloves</p>				

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	<p>and cleansed her hands appropriately. The RN then retrieved more gloves and tape from the patient's supply and changed her gloves without cleansing her hands.</p> <p>B. After completing the dressing change, the RN pulled the patient's soiled underwear and pants up over the clean dressing. The RN stated to the patient, "You might want to change those afterwhile."</p> <p>C. The supervising nurse, employee B, was present also during this home visit and made the same observations. The supervising nurse indicated, on 4-29-13 at 10:15 AM, the RN, employee K, did not address the soiled underwear situation appropriately.</p> <p>8. A home visit was made to patient number 8 on 4-29-13 at 10:00 AM with employee L, a registered nurse. The RN was observed to perform a dressing change to the patient's left lower arm. Clinical record number 8 evidenced the patient had a diagnosis of infection with <i>Clostridium difficile</i>, a bacterial infection that causes diarrhea and other intestinal problems.</p> <p>A. The Association For Professionals in Infection Control and Epidemiology</p>				

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	<p>(APIC) "Guide to the Elimination of <i>Clostridium difficile</i> in Healthcare Settings" states, "Common antimicrobial agents (including alcohols, chlorhexidine, hexachlorophene, iodophors, PCMS, and triclosan) for hand washing are not active against spores. The benefit of hand washing with soap and water is the physical removal and dilution of spores from the hands."</p> <p>1.) The June 2010, Vol. 31, No 6, issue of the Infection Control and Hospital Epidemiology publication states, "Reexamining Methods and Messaging for Hand Hygiene in the Era of Increasing <i>Clostridium difficile</i> Colonization and Infection . . . Although ABHR [alcohol based hand rubs] has excellent germicidal activity against a broad spectrum of bacteria and viruses . . . ABHR is not efficacious against spore-forming organisms, such as <i>Clostridium difficile</i>."</p> <p>2.). The Centers for Disease Control and Prevention "Vital Signs: Stop <i>C. difficile</i> Infections" states, "Wear gloves and gowns when treating <i>C. difficile</i> patients, even during short visits. Hand sanitizer does not kill <i>C. difficile</i>, and hand washing may be sufficient."</p> <p>B. The RN was observed to cleanse his hands with an ABHR and was not</p>			

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	<p>observed to wash his hands with soap and water during the dressing change. The RN completed an assessment and retrieved supplies from a bag in the patient's room. The RN then cleansed his hands with an ABHR. The RN cut the dressing to size and opened the dressing supplies. The RN then donned clean gloves without cleansing his hands with an ABHR or washing his hands with soap and water.</p> <p>C. After removing the old dressing, the RN cleansed the wound with a dry gauze and applied a clean medicated dressing without cleansing his hands or changing his gloves.</p> <p>D. After completing the dressing change, the RN changed his gloves and failed to cleanse his hands with either an ABHR or with soap and water. He then examined a healed wound on the patient's right upper arm. The RN removed his gloves and cleansed his hands with an ABHR and assisted the patient to apply oxygen per nasal cannula and a blanket.</p> <p>E. The supervising nurse, employee B, was present during this home visit and made the same observations. The supervising nurse indicated, on 4-29-13 at 11:10 AM, employee L had not followed appropriate infection control procedures</p>						

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	while providing care to the patient.			

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G000156	<p><b>484.18</b> ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure the requirements of this condition were being met creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency failed to ensure treatments and services had been provided as ordered by the physician in 6 of 16 records reviewed creating the potential to affect all of the agency's 250 current patients. (See G 158).</li> <li>2. The agency failed to ensure clinical records included plans of care that included all of the required items in 2 of 16 records reviewed creating the potential to affect all of the agency's 250 current patients. (See G 159).</li> <li>3. The agency failed to ensure orders for physical therapy (PT) included parameters for ultrasound therapy in 1 of 1 record of patients that received ultrasound treatments as a part of their therapy services creating the potential to affect all of the agency's current patients that</li> </ol>	G000156	<p>1) Please see G158 for plan of correction.2) Please see G159 for plan of correction.3) Please see G161 for plan of correction.4) Please see G164 for plan of correction.5) Please see G165 for plan of correction.Date of Completion: 5.30.13</p>	05/30/2013

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	<p>receive therapy services. (See G 161).</p> <p>4. The agency failed to ensure the registered nurse (RN) had notified the physician of a patient's deteriorating condition in 1 of 16 records reviewed creating the potential to affect all of the agency's 250 current patients. (See G 164).</p> <p>5. The agency failed to ensure treatments had been provided as ordered by the physician in 2 of 16 reviewed creating the potential to affect all of the agency's 250 current patients. (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.58 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>				

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and services had been provided as ordered by the physician in 6 (#s 3, 5, 6, 9, 12, and 15) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that included an order for an evaluation by the speech language pathologist (SLP). The plan of care states, "ST [speech therapy]: 1w1 [one time per week for 1 week] (Eval only)."</p> <p>A. The record evidenced documentation the SLP had completed the evaluation on 4-9-13 and had provided additional speech therapy services on 4-10-13 and 4-16-13. The record failed to include an order to provide the additional speech therapy visits.</p>	G000158	<p>The agency has completely overhauled processes for timely securing of physician orders, filing, etc. The Therapy Manager has implemented new processes for checking and auditing orders for each discipline at each office. The agency will send all evaluations to the physician separately to expedite the process. The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All appropriate office personnel will be in-serviced on the new procedure of securing timely physician orders and filing, by the Administrator or designee. Both coders were in-serviced by the Administrator on 5.13.13 related to always coding in "real time" and including all orders obtained</p>	05/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
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	<p>B. The supervising nurse, employee B, stated, on 4-29-13 at 3:30 PM, "The evaluation is supposed to be sent to the physician for signature for the additional visits. It was not done."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 3-31-13 to 5-29-13 that states, "MSS [medical social services] 1 w 1 MSW [medical social worker] to eval."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence the MSS evaluation had been completed within 48 hours as required by agency policy.</p> <p>C. The supervising nurse, employee B, indicated, on 5-2-13 at 12:45 PM, the MSS evaluation had not been completed within 48 hours.</p> <p>3. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on</p>		<p>in the 5-day window. All Social Workers will be in-serviced by the Administrator or designee related to the 48-hour standard/policy and procedures for evaluation. Clinical managers or designee will audit 10% of MSW evaluation orders for 3 months and then PRN as needed, to ensure compliance. All therapists will be in-serviced by the Therapy Manager or designee related to the forty-eight hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Therapy Manager or designee will audit therapy notes and new orders for timeliness and completion; she will audit 50% of all therapy notes, discharge orders for 30 days, then 10% for 3 months and then PRN as needed, to ensure compliance. All RN's will be in-serviced by the Administrator or designee related to obtaining orders for all labs. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Clinical Managers to review all lab results and to physically match the lab order to the lab results, thus ensuring the lab order is present. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying orders for wound treatments. Clinical Managers will audit 100% of all lab orders</p>				

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	<p>3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>4. Clinical record number 9 included an occupational therapy (OT) evaluation and plan of care dated 6-7-12 and signed by the physician on 7-17-12 that states, "Frequency and Duration: 1w1 2w6 [two times per week for 6 weeks]."</p> <p>A. The record evidenced the evaluation and only 2 additional visits had been provided. The record failed to evidence any additional OT visits had been provided after 6-15-12.</p> <p>B. The supervising nurse, employee B, stated, on 4-25-13 at 12:40 PM, "The service record does not show any additional visits were provided. The patient's [significant other] had called and stated the patient did not want any more therapy visits. The therapist was notified but the therapist did not get an order to</p>		<p>for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. All therapists will be in-serviced by the Therapy manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Administrator or designee will audit 50% of all charts coded in "real time" and including all orders obtained in the 5-day window. The Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of completion: 5.30.13</p>		

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	<p>discontinue the visits. There is no order to discontinue the OT visits."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN [skilled nurse] to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p>						

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	<p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities. The record failed to include an order for the use of the TED hose.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 3-14-13 to 5-12-13 that states, "PT 1w1. Physical Therapy to evaluate to established HEP [home exercise program]."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence a physical therapy evaluation had been</p>						

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	<p>completed within 48 hours of the order.</p> <p>C. The supervising nurse, employee B, indicated, on 4-30-13 at 12:05 PM, the physical therapy evaluation had not been completed within 48 hours as required by agency policy.</p> <p>7. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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G000159	<p><b>484.18(a)</b> <b>PLAN OF CARE</b></p> <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.</p> <p>Based on clinical record review and interview, the agency failed to ensure plans of care included all of the required items in 2 (#s 1 and 2) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included verbal orders dated 4-13-13 that evidenced skilled nursing (SN) was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks and physical and occupational therapy were to evaluate for the need for the services. The plan of care failed to include all pertinent diagnoses and failed to include mental status, types of equipment required, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, and any safety</li> </ol>	G000159	The Home Health Agency has developed a new form and new processes for receiving verbal orders and then sending to physician for signature on all new admits. All appropriate office personnel will be in-serviced by the Administrator or designee on the plan of care being developed in consultation with the agency. The coders will audit 100% of all charts from 5.30.13 for 30 days by utilizing the agency coding worksheet. The process will aide the home health agency in obtaining all necessary documentation much more quickly and improve timeliness of the coding and audit process. 10% of all charts will be audited to ensure compliance on an ongoing basis. The home health agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13	05/30/2013	

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	<p>measures.</p> <p>2. Clinical record number 2 included verbal orders dated 4-15-13 that evidenced SN was to be provided 1 times a day for 1 day, 2 times per week for 2 weeks and 1 time per week for 7 weeks and physical and occupational therapy were to evaluate for the need for services. The plan of care failed to include all pertinent diagnoses and failed to evidence mental status, types of equipment required, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, and any safety measures.</p> <p>3. The agency's quality assurance manager, employee P, stated, on 4-23-13 at 10:30 AM, "The 485 [plan of care] is in the computer in pieces. It is not ready to be printed. It has to go through a quality assurance process with the 'coders' first."</p>				

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G000161	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure orders for physical therapy (PT) included parameters for ultrasound therapy in 1 (# 3) of 1 record reviewed of patients that received ultrasound treatments as a part of their therapy services creating the potential to affect all of the agency's current patients that receive therapy services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit to patient number 3, on 4-24-13 at 2:45 PM, with employee I, a physical therapist, observation noted the therapist performed ultrasound therapy to the patient's left knee. The therapist stated the settings were "1.25 watts per centimeter squared for 7 minutes."</li> </ol> <p>The record included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that states, "Physical Therapy . . . Treatment . . . Ultrasound." The orders for the ultrasound treatment failed to include the settings for the machine, the location, and</p>	G000161	<p>Orders were received for specific ultrasound therapy involving the patient identified in the deficiency. The Home Health Agency has changed the process internally to send out all evaluations separately to physicians to ensure accuracy of therapy services. The specifics involve specific procedures and modalities to be used as well as the amount, frequency, and duration of therapy services. All appropriate office personnel will be in-serviced by the Administrator or designee on the change in this process. 10% of all charts will be audited to ensure compliance on an ongoing basis. The agency QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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	<p>the duration of the treatment.</p> <p>2. The supervising nurse, employee B, stated, on 4-29-13 at 3:35 PM, "The PT re-assessment includes the settings. It was not sent to the physician for signature."</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Orders for therapy services include: The specific procedures and modalities to be used."</p>			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had notified the physician of a patient's deteriorating condition in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included verbal start of care orders from the patient's primary care physician (PCP) for the certification period 4-13-13 to 6-11-13 that evidenced skilled nursing was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks. The plan also evidenced physical therapy was to be provided 2 times per week for 8 weeks and occupational therapy 1 time per week for 1 week then 2 times per week for 6 weeks. The plan of care evidenced the agency "May accept orders for [cardiologists] who are to address Cardiology issues."</p> <p>A The record included an admission skilled nurse (SN) visit note dated</p>	G000164	The RN involved in the deficiency received disciplinary action by management on 5.17.13.All RN's will be in-serviced by the Administrator or designee related to professional staff management, prompt notification to physician to changes that occur requiring the need to alter the plan of care. RN's are required to contact management for assistance if the physician does not return calls timely or if the nurse experiences difficulty in reaching the physician.All RN's will be in-serviced by the Administrator or designee related to the use of the new case conference form. Clinical Managers and team will discuss weekly at case conference all patients who have experienced any exacerbation or change in condition, so that all parties are aware of the changes.Administrator or desingee will audit 100% of all case conference agendas for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance.The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits.Date of Completion: 5.30.13	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>4-13-13 that identified the patient weighed 226 pounds, was short of breath "with minimal exertion", had a "Mitral valve replacement 3-15.13 and pacemaker placement 3-17-13", and that the patient had "significant peripheral edema. Past surgery includes cardiac surgery."</p> <p>B. A SN visit note dated 4-15-13 evidenced the patient had "plus 2 pitting edema in bilateral lower legs and feet. Patient is on oxygen at 1.5 L."</p> <p>C. A SN visit note dated 4-18-13 evidenced the patient had 3 plus pitting edema in the right and left feet and that the patient had "retraction / labored breathing . . . unable to lie flat and sleeps in chair with feet elevated." The note evidenced further the patient's weight was 238.1.</p> <p>1.) The note states, "Today [the patient's] respirations are labored and [the patient] has 3+ pitting edema to tops of feet. [The patient's spouse] called cardiologist to request increase in diuretic."</p> <p>2.) The record failed to evidence the registered nurse had contacted either the PCP or the cardiologist to inform them of the patient's increase in edema and increased difficulty breathing.</p>			

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	<p>D. A SN visit note dated 4-19-13 evidenced the patient had continued 3+ pitting edema in both feet. The note states, "pt [patient] is to take an extra dose [Lasix] today due to increased edema." The note states further, "SN made 2 attempts at venipuncture once to each AC for labs. SN contacted [name of doctor] regarding inability to get blood instructed to send pt to lab for blood draw today due to increased edema."</p> <p>E. A SN visit note dated 4-22-13 evidenced the patient's respiratory rate was 24, the patient was short of breath with minimal exertion, and was "anxious due to dyspnea." The note evidenced the patient continued with 3+ pitting edema in the feet, and that "accessory muscles used" for breathing.</p> <p>1.) The 4-22-13 SN visit note states, "Wife reports pt more dyspneic over the weekend and [the patient] is more labored today that at last visit 3 days ago. Respirations are labored and shallow at 27/minute. Pulse ox is 91% on 1/25 liters per nasal cannula . . . Pt instructed to splint ribs with a pillow and to take deep breaths . . . to use oxygen at all times . . . Wife instructed on counting respirations and instructed to call SN if rate exceeded 30/minute . . . Pt has 3+ to</p>						

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
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	<p>4+ pitting edema to bilateral feet and ankles. SN instructed [the patient] to keep feet elevated at all times and to continue with prescribed medications for edema."</p> <p>2.) The record failed to evidence the registered nurse had contacted the PCP or the cardiologist with the information the patient continued to experience difficulties.</p> <p>F. The record evidenced the SN did not contact the physician until the next day on 4-23-13. A "Case Communication Note" dated 4-23-13 evidenced the SN had contacted the cardiologist and left a voice mail message for the nurse. The note indicated the nurse returned the call later in the afternoon and the cardiologist had recommended a "pulmonology consult." The note evidenced the SN had also contacted the patient's PCP. The PCP's nurse stated, "[The PCP] had not seen this pt since well before he went into the hospital and had not been informed of events that transpired in the interim, so he felt uncomfortable assuming responsibility for home care supervision. She also stated that cardiologist had ordered home care and therapies without speaking with [primary care physician]."</p> <p>G. A SN visit note dated 4-24-13</p>						

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	<p>states, "pedal pulses weak . . . 3+ to 4+ pitting edema . . . more labored respirations that last visit 2 days ago; shallow, rapid and using shoulder muscles to breathe."</p> <p>1.) A "Case Communication Report" dated 4-24-13 states, "Pt feeling worse today than at visit 2 days ago. Respirations are more labored and he is using accessory muscles to breathe. Lungs are clear, diminished and pulse ox [oximeter] is 90% on usual oxygen flow rate of 1.25 liters / minute. [The patient] is pale and states slept poorly. States poor appetite and too tired to eat. Becomes noticeably dyspneic with walking short distances. Bilateral pedal edema 3-4+ and pitting. Urns [sic] amber in color and wt [weight] is same past 3 days with no improvement despite increased diuretic use. Skin turgor is greater than 3 at hands and less than 3 at forearms. Pt is dyspneic with talking. When SN arrive, pt stated that when [spouse] returns home, is taking him to the ER for evaluation at [cardiologist's] instruction this morning. Pt reports that [spouse] spoke with [PCP] office this morning and they are aware of [the patient's] current condition and that [the patient] is going to the ER."</p> <p>2.) The record failed to evidence the registered nurse had notified the</p>						

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>physician of the patient's continued decline and difficulty breathing.</p> <p>3.) The "Case Communication Report" dated 4-24-13 evidenced the patient's spouse had called and informed the agency the patient had been admitted to the hospital and that the patient was "on a Lasix drip for severe edema."</p> <p>2. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 4-30-13 at 3:15 PM. The supervising nurse indicated there was no further documentation of contact with either doctor on 4-24-13.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The RN or therapist promptly notifies the physician of any changes that suggests a need to modify the plan of care."</p>			

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G000165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure treatments had been provided as ordered by the physician in 2 (#s 6, &amp; 12) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on 3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test. <ul style="list-style-type: none"> <li>A. The record failed to evidence an order from the physician for the blood draw.</li> <li>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</li> </ul> </li> <li>Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to</li> </ol>	G000165	<p>The orders received by the physician on this incident, dated 3.5.13 were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying all lab orders. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months, then PRN as needed to ensure compliance. Clinical Managers to review all lab results and to physically match the lab order to the lab results, thus ensuring the lab order is present. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying orders for wound treatments. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. All RN's will</p>	05/30/2013	

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	<p>5-3-13 that states, "SN to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p> <p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p>		<p>be in-serviced by the Administrator or designee related to conformance with physician orders; that medications and treatments are administered by the home health agency staff as ordered by the physician. All therapists will be in-serviced by the Therapy Manager or designee related to obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Administrator or designee will audit 50% of all charts coded in "real time" and including all orders obtained in the 5-day window. the Administrator or designee will audit 50% of charts coded for 'real time" for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Both coders were in-serviced by the Administrator on 5.13.13 related to always coding in "real time" and including all orders obtained in the 5-day window. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>				

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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	<p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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G000170	<p><b>484.30</b> <b>SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had provided treatments in accordance with the plan of care in 2 (#s 6 and 12) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on 3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test. <ul style="list-style-type: none"> <li>A. The record failed to evidence an order from the physician for the blood draw.</li> <li>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</li> </ul> </li> <li>Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN to perform /</li> </ol>	G000170	The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying all orders for wounds and labs and to furnish skilled nursing services in accordance with the plan of care. Clinical Managers will audit 100% of all lab orders X 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Clinical Managers to review all lab results and to physically match the lab order to the lab results, thus ensuring the lab order is present. Both Coders were in-serviced by the Administrator related to always coding in "real time" and including all orders obtained in a 5-day window. Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10%	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
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	<p>instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p> <p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13,</p>		for 3 months and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of completion: 5.30.13				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>			

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G000176	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had notified the physician of a patient's deteriorating condition in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included verbal start of care orders from the patient's primary care physician (PCP) for the certification period 4-13-13 to 6-11-13 that evidenced skilled nursing was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks. The plan also evidenced physical therapy was to be provided 2 times per week for 8 weeks and occupational therapy 1 time per week for 1 week then 2 times per week for 6 weeks. The plan of care evidenced the agency "May accept orders for [cardiologists] who are to address Cardiology issues."</p>	G000176	The RN involved in the deficiency received disciplinary action by management on 5.17.13. All RN's will be in-serviced by the Administrator or designee related to professional staff management, prompt notification to physician to changes that occur requiring the need to alter the plan of care. RN's are required to contact management for assistance if the physician does not return calls timely or if the nurse experiences difficulty in reaching the physician. All RN's will be in-serviced by the Administrator or designee related to the use of the new case conference form. Clinical Managers and team will discuss weekly at case conference all patients who have experienced any exacerbation or change in condition, so that all parties are aware of the changes. Administrator or desinee will audit 100% of all case conference agendas for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date	05/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
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	<p>A The record included an admission skilled nurse (SN) visit note dated 4-13-13 that identified the patient weighed 226 pounds, was short of breath "with minimal exertion", had a "Mitral valve replacement 3-15.13 and pacemaker placement 3-17-13", and that the patient had "significant peripheral edema. Past surgery includes cardiac surgery."</p> <p>B. A SN visit note dated 4-15-13 evidenced the patient had "plus 2 pitting edema in bilateral lower legs and feet. Patient is on oxygen at 1.5 L."</p> <p>C. A SN visit note dated 4-18-13 evidenced the patient had 3 plus pitting edema in the right and left feet and that the patient had "retraction / labored breathing . . . unable to lie flat and sleeps in chair with feet elevated." The note evidenced further the patient's weight was 238.1.</p> <p>1.) The note states, "Today [the patient's] respirations are labored and [the patient] has 3+ pitting edema to tops of feet. [The patient's spouse] called cardiologist to request increase in diuretic."</p> <p>2.) The record failed to evidence the registered nurse had contacted either the PCP or the cardiologist to inform</p>		of Completion: 5.30.13				

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>them of the patient's increase in edema and increased difficulty breathing.</p> <p>D. A SN visit note dated 4-19-13 evidenced the patient had continued 3+ pitting edema in both feet. The note states, "pt [patient] is to take an extra dose [Lasix] today due to increased edema." The note states further, "SN made 2 attempts at venipuncture once to each AC for labs. SN contacted [name of doctor] regarding inability to get blood instructed to send pt to lab for blood draw today due to increased edema."</p> <p>E. A SN visit note dated 4-22-13 evidenced the patient's respiratory rate was 24, the patient was short of breath with minimal exertion, and was "anxious due to dyspnea." The note evidenced the patient continued with 3+ pitting edema in the feet, and that "accessory muscles used" for breathing.</p> <p>1.) The 4-22-13 SN visit note states, "Wife reports pt more dyspneic over the weekend and [the patient] is more labored today that at last visit 3 days ago. Respirations are labored and shallow at 27/minute. Pulse ox is 91% on 1/25 liters per nasal cannula . . . Pt instructed to splint ribs with a pillow and to take deep breaths . . . to use oxygen at all times . . . Wife instructed on counting</p>			

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	<p>respirations and instructed to call SN if rate exceeded 30/minute . . . Pt has 3+ to 4+ pitting edema to bilateral feet and ankles. SN instructed [the patient] to keep feet elevated at all times and to continue with prescribed medications for edema."</p> <p>2.) The record failed to evidence the registered nurse had contacted the PCP or the cardiologist with the information the patient continued to experience difficulties.</p> <p>F. The record evidenced the SN did not contact the physician until the next day on 4-23-13. A "Case Communication Note" dated 4-23-13 evidenced the SN had contacted the cardiologist and left a voice mail message for the nurse. The note indicated the nurse returned the call later in the afternoon and the cardiologist had recommended a "pulmonology consult." The note evidenced the SN had also contacted the patient's PCP. The PCP's nurse stated, "[The PCP] had not seen this pt since well before he went into the hospital and had not been informed of events that transpired in the interim, so he felt uncomfortable assuming responsibility for home care supervision. She also stated that cardiologist had ordered home care and therapies without speaking with [primary care physician]."</p>			

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>G. A SN visit note dated 4-24-13 states, "pedal pulses weak . . . 3+ to 4+ pitting edema . . . more labored respirations that last visit 2 days ago; shallow, rapid and using shoulder muscles to breathe."</p> <p>1.) A "Case Communication Report" dated 4-24-13 states, "Pt feeling worse today than at visit 2 days ago. Respirations are more labored and he is using accessory muscles to breathe. Lungs are clear, diminished and pulse ox [oximeter] is 90% on usual oxygen flow rate of 1.25 liters / minute. [The patient] is pale and states slept poorly. States poor appetite and too tired to eat. Becomes noticeably dyspneic with walking short distances. Bilateral pedal edema 3-4+ and pitting. Urns [sic] amber in color and wt [weight] is same past 3 days with no improvement despite increased diuretic use. Skin turgor is greater than 3 at hands and less than 3 at forearms. Pt is dyspneic with talking. When SN arrive, pt stated that when [spouse] returns home, is taking him to the ER for evaluation at [cardiologist's] instruction this morning. Pt reports that [spouse] spoke with [PCP] office this morning and they are aware of [the patient's] current condition and that [the patient] is going to the ER."</p>			

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
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	<p>2.) The record failed to evidence the registered nurse had notified the physician of the patient's continued decline and difficulty breathing.</p> <p>3.) The "Case Communication Report" dated 4-24-13 evidenced the patient's spouse had called and informed the agency the patient had been admitted to the hospital and that the patient was "on a Lasix drip for severe edema."</p> <p>2. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 4-30-13 at 3:15 PM. The supervising nurse indicated there was no further documentation of contact with either doctor on 4-24-13.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The RN or therapist promptly notifies the physician of any changes that suggests a need to modify the plan of care."</p>						

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G000211	<p><b>484.36(b)(1)</b> <b>COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</b> An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file included a competency evaluation dated 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs and urinary catheter care.</li> <li>2. The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the individual had been evaluated for the competent performance of vital signs or</li> </ol>	G000211	HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13	05/30/2013			

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	urinary catheter care.			

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
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G000213	<p><b>484.36(b)(2)(i) COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</b> The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section. Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs as required by 42 CFR 484.36(a)(iii) and urinary catheter care as a part of toileting and elimination as required by 42 CFR 484.36(a)(ix)(F).</li> <li>The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the</li> </ol>	G000213	HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	individual had been evaluated for the competent performance of vital signs or urinary catheter care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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G000236	<p><b>484.48</b> <b>CLINICAL RECORDS</b> 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 and agency policy review and interview, the agency failed to ensure clinical notes had been incorporated into the medical record weekly as required by the agency's policy in 1 (# 6) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 6 included a plan of care established by the physician for the certification period 3-15-13 to 5-13-13 that identified occupational therapy (OT) was to be provided 1 time per week for 1 week then 2 times per week for 8 weeks and that physical therapy (PT) was to be provided 1 time per week for 1 week then 2 times per week for 5 weeks.</li> </ol> <p>A. The record failed to include clinical notes for PT services provided on</p>	G000236	Administrator and DON revised current policy #3013 related to timely filing to state that all paperwork is to be entered/filed into patient's chart within 14 days. The agency added a part-time receptionist to one branch (Huntingburg, IN) to better aide in timely filing. As of 5.30.13, all filing is current at each location, with staffing in place to ensure this. Therapy Manager has new process in place to ensure timely receipt and filing of therapy notes. Office Manager has new process in place with office personnel to ensure timely processing of paperwork, mailing to physicians, and filing on charts. Therapy Manager has been in-serviced on new process on 5.14.13. Appropriate office staff have been in-serviced on new process on 5.13.13. Receptionists/filers at each location will be in-serviced on new processes by	05/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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	<p>3-15-13, 3-19-13, 3-22-13, 3-27-13, 3-29-13, 4-1-13, 4-3-13, and 4-9-13. The branch clinical manager, employee O, provided clinical notes for the PT services when asked on 4-25-13 at 10:25 AM. The manager stated, "I don't have a reason why the notes were not filed in the chart."</p> <p>B. The record failed to include clinical notes for OT services provided on 3-15-13, 3-18-13, 3-20-13, 3-25-13, 3-29-13, and 4-3-13. The branch clinical manager, employee O, provided clinical notes for the OT services when asked on 4-25-13 at 10:25 AM. The manager stated, "I don't have a reason why the notes were not filed in the chart."</p> <p>2. The agency's 2009 "Confidentiality" policy number 3013 states, "Original records can be initiated outside the Vibrant! office, but must be submitted to the corporate office within forty-eight (48) hours and incorporated in the clinical record weekly."</p>		<p>5.30.13 Administrator or designee will audit 100% of filing weekly, using the audit tool, to ensure timely filing for 3 months at each location and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
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G000321	<p><b>484.20(a)</b> <b>ENCODING OASIS DATA</b> The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review, agency validation report review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion in 7 (#s 3, 4, 6, 7, 8, 10, and 16 ) of 9 records reviewed of patients that had been on service for longer than 90 days (60 days for the recertification plus 30 additional days to transmit) creating the potential to affect all of the agency's skilled Medicare and/or Medicaid patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 3 included a start of care comprehensive assessment with a completion date of 2-7-13. The agency's "OASIS Final Validation Report" evidenced the assessment had not been successfully transmitted until 3-15-13.</li> <li>2. Clinical record number 4 included a start of care comprehensive assessment with a completion date of 1-10-13. The agency's "OASIS Final Validation Report" evidenced the assessment had not</li> </ol>	G000321	<p>The agency hired a third-party coding company in December, 2012, to assist in updating and remaining current on all Oasis, coding and other associated documentation. All coding will be current effective the alleged date of compliance, 5.30.13. QA staff is checking the pending Oasis assessments daily and are forwarding necessary documentation to clinical managers at each location. Once received, the Clinical Managers contact the appropriate staff to request they come to the appropriate office to complete paperwork as needed. Oasis informaation is now being transmitted as often as needed, but at a minimum of one time per week. Administrator or designee will audit 100% of daily reports to Clinical Managers for 3 months at each location and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>	05/30/2013			

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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	<p>been successfully transmitted until 3-15-13.</p> <p>3. Clinical record number 6 included an update to the comprehensive assessment with a completion date of 1-10-13. ISDH documents evidenced the assessment had not been successfully transmitted until 2-27-13.</p> <p>4. Clinical record number 7 included an update to the comprehensive assessment with a completion date of 1-4-13. ISDH documents evidenced the assessment had not been successfully transmitted until 2-22-13.</p> <p>5. Clinical record number 8 included a resumption of care comprehensive assessment with completion date of 2-5-13. ISDH documents evidenced the assessment had not been successfully transmitted until 3-11-13.</p> <p>6. Clinical record number 10 included a start of care comprehensive assessment with a completion date of 12-29-12. ISDH documents evidenced the assessment had not been successfully transmitted until 2-8-13.</p> <p>7. Clinical record number 13 included a start of care comprehensive assessment with a completion date of 2-13-13. The</p>				

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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	<p>agency's "OASIS Final Validation Report" evidenced the assessment had not been successfully transmitted until 3-21-13.</p> <p>8. Clinical record number 16 included a start of care comprehensive assessment with a completion date of 10-11-12. ISDH documents evidenced the assessment had not been successfully transmitted until 11-16-12.</p> <p>The record included an update to the comprehensive assessment with a completion date of 12-07-12. ISDH documents evidenced the assessment had not been successfully transmitted until 2-7-13.</p> <p>9. The administrator, employee A, stated, during the entrance conference on 4-23-13 at 8:50 AM, "We are aware of the late transmissions. We have had Internet problems since we moved to this building. We have been working on it. I think you will see an improvement in the last 2 weeks."</p>				

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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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N000000	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 4-23-13, 4-24-13, 4-25-13, &amp; 4-29-13, 4-30-13 &amp; 5-1-13</p> <p>Facility #: 005940</p> <p>Medicaid Vendor #: 100265610A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 250 skilled, 0 home health aide only, 0 personal services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 8, 2013</p>	N000000	<p>The submission of this Plan of Correction does not indicate an admission by Care One Home Health that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the patients of Care One Home Health. This Home Health Agency recognized its obligation to provide legally and medically necessary care and services to its patients in an economic and efficient manner. Care One Home Health hereby maintains it is in substantial compliance with the requirements of participation for home health agencies. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this agency. It is thus submitted as a matter of statute only.</p>		

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N000458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel file review and interview, the agency failed to ensure personnel files included copies of limited criminal histories pursuant to IC 16-27-2 in 2 (files H and I) of 11 employee files reviewed of individuals hired since the last survey on May 21, 2010 creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Personnel file H evidenced the individual had been hired on 12-10-12 to provide skilled nursing services on behalf of the agency. The file failed to evidence a criminal history from the Indiana central repository for criminal history</p>	N000458	<p>1) Personnel file H has a criminal history from the Indiana central repository; agency uses Sterling Infosystems, Inc., and they check State of Indiana criminal seraches through the Indiana State Police. Personnel file H has a hire date of 12.10.12, and the background check was completed on 11.27.12.2) Personnel file I has a criminal history from the Indiana central repository; agency uses Sterling Infosystems, Inc., and they check State of Indiana criminal seraches through the Indiana State Police. Personnel file I has a hire date of 5.21.12, and the background check was completed on 5.16.12. We are respectfully requesting an IDR of this tag, as Sterling Infosystems,</p>	05/17/2013			

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	<p>information had been obtained.</p> <p>2. Personnel file I evidenced the individual had been hired on 5-21-12 to provide physical therapy services on behalf of the agency. The file failed to evidence a criminal history from the Indiana central repository for criminal history information had been obtained.</p> <p>3. The office manager, employee R, stated, on 5-1-13 at 10:30 AM, "We get all of our background checks from [private company] now." The manager was unable to determine if the private company obtained their criminal history information from the Indiana central repository.</p>		<p>Inc., checks the Indiana State Police. (Pease see IDR letter and information).Date of Completion: 5.17.13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
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N000462	<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.</p> <p>Based on personnel file review and interview, the agency failed to ensure each employee file included a physical examination that had been completed no more than 180 days from the first patient contact date in 1 (file J) of 11 files reviewed of individuals hired since the last survey on 5-21-10.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file J evidenced the individual had been hired on 10-25-10 to provide skilled nursing services on behalf of the agency. The medical file failed to evidence a physical examination that had been completed no more than 180 days prior to the first patient contact date. The file evidenced the first patient contact date was 5-21-10.</li> <li>2. The office manager, employee R, indicated, on 5-1-13 at 10:40 AM, that</li> </ol>	N000462	<p>Employee "J" is a long-term employee of our parent company; she had no breaks in her employment between working for our Trilogy LTCF side and transferring to work for us; therefore, no new physical examination was required. However, since the State doesn't recognize this association as part of the same company, Care One should have then obtained this. Effective 5.30.13, all Trilogy employees who opt to work for Care One, will be treated as a newly hired employee and will follow our 180 day health examination standard. All management staff in-serviced on 5.14.13 r/t all Trilogy employees to be treated as new employees. Administrator or designee to audit 100% of all Trilogy transferred employees and 100% of all newly hired employees for 3 months, then on-going as needed.</p>	05/30/2013	

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	file J did not evidence a physical examination that was no more than 180 days prior to patient contact.				

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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, agency policy and clinical record review, document review, and interview, the agency failed to ensure its staff provided services in accordance with its own infection control policies and procedures and the Centers for Disease Control and other infection control documents in 6 (#s 3, 4, 5, 6, 7, and 8) of 8 home visit observations creating the potential for the spread of disease causing organisms among staff and all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Universal Body Substance Precaution" policy # 4014 states, "Agency personnel will adhere to the following precautions . . . Personal Protective Equipment . . . All personnel must use appropriate personal protective equipment . . . Handwashing: Handwashing will be performed to prevent cross-contamination between patients/clients and personnel. Hands and other skin surfaces should be washed with soap and warm water immediately and</p>	N000470	<p>Patient identified was immediately transferred to the bathroom and changed clothes prior to the RN leaving the home. DON updated Policy #4107 to clarify between using soap and water vs. hand gel, unless contraindicated for specific organism. All HHA's will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All HHA's will perform a return demonstration for appropriate technique. All staff will be in-serviced by the Administrator or designee related to pets in the home and how to safely work around pets while keeping an appropriate clean barrier in place. All staff will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All staff will perform a return demonstration for appropriate technique. All therapists will be in-serviced by the Therapy Manager or designee related to Universal Precautions</p>	05/30/2013			

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	<p>thoroughly before and after patient/client contact, if contaminated with body substances, before and after gloves are worn . . . Gloves: . . . Gloves are to be worn by all agency staff when direct patient contact with any body substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind). Gloves are to be worn when contact with non-intact skin is anticipated. Gloves are to be worn when handling soiled linens."</p> <p>The agency's undated "Handwashing" policy number 4017 states, "Personnel providing care/service in the home setting will wash their hands: . . . Before and after each contact with a patient/client, After handling bed pans, urinals, catheters, linens, before and after gloves are removed."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body</p>		<p>and utilizing ultrasound gel.All staff will be in-serviced by the Administrator or designee related to complying with acceptable professional standards and principles of hand washing and Universal Precautions. All staff will perform a return demonstration for appropriate technique. All staff will be in-serviced by the Administrator or designee related to the CDC's guidelines for safely caring for patients with active C-Dificil.Administrator/DON in-serviced all Clinical Managers on 5.14.13 related to complying with acceptable professional standards and principles of handwashing and Universal Precautions, safely working around pets while keeping an appropriate clean barrier in place and the CDC's guidelines for safely caring for patients with active C-Dificil.Each Clinical Manager assigned to each home health location will ride along with at least one employee per month for three months, utilizing an observation checklist, to ensure compliance with acceptable practices of infection control and Universal Precautions.Each Clinical Manager assigned to each location will also ride along with employee at time of annual evaluation and prior to the employee being released to the field, if newly hired, to ensure compliance.Administrator or designee to monitor for ongoing</p>		

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	<p>fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 5 on 4-23-13 at 10:05 AM with employee D, a home health aide. The aide was observed to assist the patient with a bath. The aide placed her nursing bag on a barrier on a chair near the</p>		<p>compliance. The agency's QA team to meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>		

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	<p>patient. The patient's dog was observed to jump up into the chair and sniff the nursing bag. The aide was not observed to discourage the dog from sitting the chair or to remove the dog from the chair.</p> <p>A. The patient was seated in a wheelchair throughout the bath procedure. The aide was observed to assist the patient to stand using a walker for assistance. The aide washed and rinsed the front perineal area then the buttocks and rectal area. Without changing her gloves or cleansing her hands, the aide then assisted the patient to sit and rest. While the patient was seated, the aide placed a Depends and pants over the patient's feet in preparation to pull them up when the patient stood. The aide then assisted the patient to stand and pulled the Depends and pants up to the patient's waist.</p> <p>B. After assisting the patient to sit again and while wearing the same gloves, the aide then emptied the bath water into the sink and put away the bath supplies. The aide then removed her gloves and, without cleansing her hands, put away the bowl used to hold the bath water. The aide then retrieved a hairbrush and brushed the patient's hair. The aide then washed her hands.</p>				

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	<p>4. A home visit was made to patient 4 on 4-24-13 at 1:05 PM with employee H, a registered nurse (RN). The RN was observed to perform a wound vacuum dressing change to the patient's sternum. After completing the assessment, the RN removed her gloves and cleansed her hands. She removed the patient's shirt and covered the patient's upper body with a towel obtained from the patient's supply. The RN then donned clean gloves without cleansing her hands. The RN removed the suction machine from its bag and disposed of the used canister. She then removed her gloves and, without cleansing her hands, gathered the supplies needed for the dressing change. The RN then donned clean gloves without cleansing her hands and removed the old dressing. The RN removed her gloves and, without cleansing her hands, gathered more supplies from a bag in the patient's home. The RN then cleaned her hands and donned clean gloves.</p> <p>After cutting the black foam and drape pieces to size, the RN cleansed the wound with a normal saline soaked gauze. Without changing her gloves and cleansing her hands, the RN completed the dressing change.</p> <p>5. A home visit was made to patient number 3 on 4-24-13 at 2:45 PM with</p>						

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	<p>employee I, a physical therapist. The therapist was observed to provide an ultrasound treatment to the patient's left knee. After the treatment was completed, the therapist wiped the gel from the patient's knee and changed his gloves without cleansing his hands. The therapist turned the machine off and placed the cords in their proper place. The therapist then massaged the left knee and wiped away the remaining gel. The therapist then removed his gloves and cleansed his hands.</p> <p>6. A home visit was made to patient number 6 on 4-25-13 at 9:00 AM with employee J, a registered nurse. The RN was observed to perform a dressing change to the patient's left ankle. The RN prepared the workspace and supplies and donned clean gloves without cleansing her hands. The RN touched a TV remote and then needed to retrieve some supplies from her car. She removed her gloves and cleansed her hands and retrieved the supplies from her car. She cleansed her hands and placed some gloves and other supplies retrieved from a bag in the patient's home onto the work area. She then cleaned her scissors and donned clean gloves without cleansing her hands. She cleansed the wound with normal saline and dried it with a clean piece of gauze. Without changing her gloves and</p>						

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	<p>cleansing her hands, the RN completed the dressing change.</p> <p>After completing the dressing change, the RN changed her gloves without cleansing her hands. She then cleaned the scissors and gathered the trash for disposal. After disposing of the trash, the RN removed her gloves and cleansed her hands.</p> <p>7. A home visit was made to patient number 7 on 4-29-13 at 9:40 AM with employee K, a registered nurse. The RN was observed to perform a dressing change to the inner aspects of the patient's gluteal folds. The patient stood while the RN changed the dressing. When the RN pulled the patient's pants and underwear down to access the wound, a moderate amount of feces was observed in the patient's underwear and on the dressing. The RN removed the dressing and cleansed the patient's rectal area removing the feces.</p> <p>A. After cleansing the wounds with normal saline soaked gauze, the RN removed her gloves and cleansed her hands. The RN retrieved her scissors and opened packages of gauze obtained from the patient's supply in the home. The RN then donned clean gloves without cleansing her hands. The RN cut the</p>						

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	<p>dressings to size and changed her gloves and cleansed her hands appropriately. The RN then retrieved more gloves and tape from the patient's supply and changed her gloves without cleansing her hands.</p> <p>B. After completing the dressing change, the RN pulled the patient's soiled underwear and pants up over the clean dressing. The RN stated to the patient, "You might want to change those afterwhile."</p> <p>C. The supervising nurse, employee B, was present also during this home visit and made the same observations. The supervising nurse indicated, on 4-29-13 at 10:15 AM, the RN, employee K, did not address the soiled underwear situation appropriately.</p> <p>8. A home visit was made to patient number 8 on 4-29-13 at 10:00 AM with employee L, a registered nurse. The RN was observed to perform a dressing change to the patient's left lower arm. Clinical record number 8 evidenced the patient had a diagnosis of infection with <i>Clostridium difficile</i>, a bacterial infection that causes diarrhea and other intestinal problems.</p> <p>A. The Association For Professionals</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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	<p>in Infection Control and Epidemiology (APIC) "Guide to the Elimination of <i>Clostridium difficile</i> in Healthcare Settings" states, "Common antimicrobial agents (including alcohols, chlorhexidine, hexachlorophene, iodophors, PCMS, and triclosan) for hand washing are not active against spores. The benefit of hand washing with soap and water is the physical removal and dilution of spores from the hands."</p> <p>1.) The June 2010, Vol. 31, No 6, issue of the Infection Control and Hospital Epidemiology publication states, "Reexamining Methods and Messaging for Hand Hygiene in the Era of Increasing <i>Clostridium difficile</i> Colonization and Infection . . . Although ABHR [alcohol based hand rubs] has excellent germicidal activity against a broad spectrum of bacteria and viruses . . . ABHR is not efficacious against spore-forming organisms, such as <i>Clostridium difficile</i>."</p> <p>2.). The Centers for Disease Control and Prevention "Vital Signs: Stop <i>C. difficile</i> Infections" states, "Wear gloves and gowns when treating <i>C. difficile</i> patients, even during short visits. Hand sanitizer does not kill <i>C. difficile</i>, and hand washing may be sufficient."</p> <p>B. The RN was observed to cleanse</p>			

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	<p>his hands with an ABHR and was not observed to wash his hands with soap and water during the dressing change. The RN completed an assessment and retrieved supplies from a bag in the patient's room. The RN then cleansed his hands with an ABHR. The RN cut the dressing to size and opened the dressing supplies. The RN then donned clean gloves without cleansing his hands with an ABHR or washing his hands with soap and water.</p> <p>C. After removing the old dressing, the RN cleansed the wound with a dry gauze and applied a clean medicated dressing without cleansing his hands or changing his gloves.</p> <p>D. After completing the dressing change, the RN changed his gloves and failed to cleanse his hands with either an ABHR or with soap and water. He then examined a healed wound on the patient's right upper arm. The RN removed his gloves and cleansed his hands with an ABHR and assisted the patient to apply oxygen per nasal cannula and a blanket.</p> <p>E. The supervising nurse, employee B, was present during this home visit and made the same observations. The supervising nurse indicated, on 4-29-13 at 11:10 AM, employee L had not followed</p>			

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	appropriate infection control procedures while providing care to the patient.			

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N000522	<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 and agency policy review and interview, the agency failed to ensure treatments and services had been provided as ordered by the physician in 6 (#s 3, 5, 6, 9, 12, and 15) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that included an order for an evaluation by the speech language pathologist (SLP). The plan of care states, "ST [speech therapy]: 1w1 [one time per week for 1 week] (Eval only)."</p> <p>A. The record evidenced documentation the SLP had completed the evaluation on 4-9-13 and had provided additional speech therapy services on 4-10-13 and 4-16-13. The record failed to include an order to provide the additional speech therapy visits.</p>	N000522	The agency has completely overhauled processes for timely securing of physician orders, filing, etc. The Therapy Manager has implemented new processes for checking and auditing orders for each discipline at each office. The agency will send all evaluations to the physician separately to expedite the process. The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All appropriate office personnel will be in-serviced on the new procedure of securing timely physician orders and filing, by the Administrator or designee. Both coders were in-serviced by the Administrator on 5.13.13 related to always coding in "real time" and including all orders obtained	05/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
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	<p>B. The supervising nurse, employee B, stated, on 4-29-13 at 3:30 PM, "The evaluation is supposed to be sent to the physician for signature for the additional visits. It was not done."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 3-31-13 to 5-29-13 that states, "MSS [medical social services] 1 w 1 MSW [medical social worker] to eval."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence the MSS evaluation had been completed within 48 hours as required by agency policy.</p> <p>C. The supervising nurse, employee B, indicated, on 5-2-13 at 12:45 PM, the MSS evaluation had not been completed within 48 hours.</p> <p>3. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on</p>		<p>in the 5-day window. All Social Workers will be in-serviced by the Administrator or designee related to the 48-hour standard/policy and procedures for evaluation. Clinical managers or designee will audit 10% of MSW evaluation orders for 3 months and then PRN as needed, to ensure compliance. All therapists will be in-serviced by the Therapy Manager or designee related to the 38 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Therapy Manager or designee will audit therapy notes and new orders for timeliness and completion; she will audit 50% of all therapy notes, discharge orders for 30 days, then 10% for 3 months and then PRN as needed, to ensure compliance. All RN's will be in-serviced by the Administrator or designee related to obtaining orders for all labs. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Clinical Managers to review all lab results and to physically match the lab order to the lab results, thus ensuring the lab order is present. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying orders for wound treatments. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3</p>				

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	<p>3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>4. Clinical record number 9 included an occupational therapy (OT) evaluation and plan of care dated 6-7-12 and signed by the physician on 7-17-12 that states, "Frequency and Duration: 1w1 2w6 [two times per week for 6 weeks]."</p> <p>A. The record evidenced the evaluation and only 2 additional visits had been provided. The record failed to evidence any additional OT visits had been provided after 6-15-12.</p> <p>B. The supervising nurse, employee B, stated, on 4-25-13 at 12:40 PM, "The service record does not show any additional visits were provided. The patient's [significant other] had called and stated the patient did not want any more therapy visits. The therapist was notified but the therapist did not get an order to</p>		<p>months and then PRN as needed to ensure compliance. All therapists will be in-serviced by the Therapy manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Administrator or designee will audit 50% of all charts coded in "real time" and including all orders obtained in the 5-day window. The Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of completion: 5.30.13</p>		

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	<p>discontinue the visits. There is no order to discontinue the OT visits."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN [skilled nurse] to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p>						

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	<p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities. The record failed to include an order for the use of the TED hose.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 3-14-13 to 5-12-13 that states, "PT 1w1. Physical Therapy to evaluate to established HEP [home exercise program]."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence a physical therapy evaluation had been</p>						

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	<p>completed within 48 hours of the order.</p> <p>C. The supervising nurse, employee B, indicated, on 4-30-13 at 12:05 PM, the physical therapy evaluation had not been completed within 48 hours as required by agency policy.</p> <p>7. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure plans of care included all of the required items in 3 (#s 1, 2, &amp; 3) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included verbal orders dated 4-13-13 that</li> </ol>	N000524	The Home Health Agency has developed a new form and new processes for receiving verbal orders and then sending to physician for signature on all new admits. All appropriate office personnel will be in-serviced by the Administrator or designee on the plan of care being developed in consultation with the agency. The coders will audit 100% of all charts from 5.30.13 for 30 days by utilizing the agency coding worksheet. The process will aide the home health agency	05/30/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
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	<p>evidenced skilled nursing (SN) was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks and physical and occupational therapy were to evaluate for the need for the services. The plan of care failed to include all pertinent diagnoses and failed to include mental status, types of equipment required, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, and any safety measures.</p> <p>2. Clinical record number 2 included verbal orders dated 4-15-13 that evidenced SN was to be provided 1 times a day for 1 day, 2 times per week for 2 weeks and 1 time per week for 7 weeks and physical and occupational therapy were to evaluate for the need for services. The plan of care failed to include all pertinent diagnoses and failed to evidence mental status, types of equipment required, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, and any safety measures.</p> <p>3. During a home visit to patient number 3, on 4-24-13 at 2:45 PM, with employee I, a physical therapist, observation noted the therapist performed ultrasound therapy to the patient's left knee. The</p>		<p>in obtaining all necessary documentation much more quickly and improve timeliness of the coding and audit process. 10% of all charts will be audited to ensure compliance on an ongoing basis. Orders were received for specific ultrasound therapy involving the patient identified in the deficiency. The agency has changed the process internally to send out all evaluations separately to physicians to ensure accuracy of therapy services. The specifics involve specific procedures and modalities to be used as well as the amount, frequency, and duration of therapy services. All appropriate office personnel will be in-serviced by the Administrator or designee on the change in the process. 10% of all charts will be audited to ensure compliance on an ongoing basis. The home health agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits.</p>		

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	<p>therapist stated the settings were "1.25 watts per centimeter squared for 7 minutes."</p> <p>A. The record included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that states, "Physical Therapy . . . Treatment . . . Ultrasound." The orders for the ultrasound treatment failed to include the settings for the machine, the location, and the duration of the treatment.</p> <p>B. The supervising nurse, employee B, stated, on 4-29-13 at 3:35 PM, "The PT re-assessment includes the settings. It was not sent to the physician for signature."</p> <p>C. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Orders for therapy services include: The specific procedures and modalities to be used."</p> <p>4. The agency's quality assurance manager, employee P, stated, on 4-23-13 at 10:30 AM, "The 485 [plan of care] is in the computer in pieces. It is not ready to be printed. It has to go through a quality assurance process with the 'coders' first."</p>				

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had notified the physician of a patient's deteriorating condition in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included verbal start of care orders from the patient's primary care physician (PCP) for the certification period 4-13-13 to 6-11-13 that evidenced skilled nursing was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks. The plan also evidenced physical therapy was to be provided 2 times per week for 8 weeks and occupational therapy 1 time per week for 1 week then 2 times per week for 6 weeks. The plan of care evidenced the agency "May accept orders for [cardiologists] who are to address Cardiology issues."</p>	N000527	The RN involved in the deficiency received disciplinary action by management on 5.17.13.All RN's will be in-serviced by the Administrator or designee related to professional staff management, prompt notification to physician to changes that occur requiring the need to alter the plan of care. RN's are required to contact management for assistance if the physician does not return calls timely or if the nurse experiences difficulty in reaching the physician.All RN's will be in-serviced by the Administrator or designee related to the use of the new case conference form. Clinical Managers and team will discuss weekly at case conference all patients who have experienced any exacerbation or change in condition, so that all parties are aware of the changes.Administrator or desingee will audit 100% of all case conference agendas for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance.The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013	
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	<p>A The record included an admission skilled nurse (SN) visit note dated 4-13-13 that identified the patient weighed 226 pounds, was short of breath "with minimal exertion", had a "Mitral valve replacement 3-15.13 and pacemaker placement 3-17-13", and that the patient had "significant peripheral edema. Past surgery includes cardiac surgery."</p> <p>B. A SN visit note dated 4-15-13 evidenced the patient had "plus 2 pitting edema in bilateral lower legs and feet. Patient is on oxygen at 1.5 L."</p> <p>C. A SN visit note dated 4-18-13 evidenced the patient had 3 plus pitting edema in the right and left feet and that the patient had "retraction / labored breathing . . . unable to lie flat and sleeps in chair with feet elevated." The note evidenced further the patient's weight was 238.1.</p> <p>1.) The note states, "Today [the patient's] respirations are labored and [the patient] has 3+ pitting edema to tops of feet. [The patient's spouse] called cardiologist to request increase in diuretic."</p> <p>2.) The record failed to evidence the registered nurse had contacted either</p>		necessity of ongoing audits.Date of Completion: 5.30.13				

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	<p>the PCP or the cardiologist to inform them of the patient's increase in edema and increased difficulty breathing.</p> <p>D. A SN visit note dated 4-19-13 evidenced the patient had continued 3+ pitting edema in both feet. The note states, "pt [patient] is to take an extra dose [Lasix] today due to increased edema." The note states further, "SN made 2 attempts at venipuncture once to each AC for labs. SN contacted [name of doctor] regarding inability to get blood instructed to send pt to lab for blood draw today due to increased edema."</p> <p>E. A SN visit note dated 4-22-13 evidenced the patient's respiratory rate was 24, the patient was short of breath with minimal exertion, and was "anxious due to dyspnea." The note evidenced the patient continued with 3+ pitting edema in the feet, and that "accessory muscles used" for breathing.</p> <p>1.) The 4-22-13 SN visit note states, "Wife reports pt more dyspneic over the weekend and [the patient] is more labored today that at last visit 3 days ago. Respirations are labored and shallow at 27/minute. Pulse ox is 91% on 1/25 liters per nasal cannula . . . Pt instructed to splint ribs with a pillow and to take deep breaths . . . to use oxygen at all times</p>				

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	<p>. . . Wife instructed on counting respirations and instructed to call SN if rate exceeded 30/minute . . . Pt has 3+ to 4+ pitting edema to bilateral feet and ankles. SN instructed [the patient] to keep feet elevated at all times and to continue with prescribed medications for edema."</p> <p>2.) The record failed to evidence the registered nurse had contacted the PCP or the cardiologist with the information the patient continued to experience difficulties.</p> <p>F. The record evidenced the SN did not contact the physician until the next day on 4-23-13. A "Case Communication Note" dated 4-23-13 evidenced the SN had contacted the cardiologist and left a voice mail message for the nurse. The note indicated the nurse returned the call later in the afternoon and the cardiologist had recommended a "pulmonology consult." The note evidenced the SN had also contacted the patient's PCP. The PCP's nurse stated, "[The PCP] had not seen this pt since well before he went into the hospital and had not been informed of events that transpired in the interim, so he felt uncomfortable assuming responsibility for home care supervision. She also stated that cardiologist had ordered home care and therapies without</p>						

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	<p>speaking with [primary care physician]."</p> <p>G. A SN visit note dated 4-24-13 states, "pedal pulses weak . . . 3+ to 4+ pitting edema . . . more labored respirations that last visit 2 days ago; shallow, rapid and using shoulder muscles to breathe."</p> <p>1.) A "Case Communication Report" dated 4-24-13 states, "Pt feeling worse today than at visit 2 days ago. Respirations are more labored and he is using accessory muscles to breathe. Lungs are clear, diminished and pulse ox [oximeter] is 90% on usual oxygen flow rate of 1.25 liters / minute. [The patient] is pale and states slept poorly. States poor appetite and too tired to eat. Becomes noticeably dyspneic with walking short distances. Bilateral pedal edema 3-4+ and pitting. Urns [sic] amber in color and wt [weight] is same past 3 days with no improvement despite increased diuretic use. Skin turgor is greater than 3 at hands and less than 3 at forearms. Pt is dyspneic with talking. When SN arrive, pt stated that when [spouse] returns home, is taking him to the ER for evaluation at [cardiologist's] instruction this morning. Pt reports that [spouse] spoke with [PCP] office this morning and they are aware of [the patient's] current condition and that [the patient] is going to the ER."</p>			

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	<p>2.) The record failed to evidence the registered nurse had notified the physician of the patient's continued decline and difficulty breathing.</p> <p>3.) The "Case Communication Report" dated 4-24-13 evidenced the patient's spouse had called and informed the agency the patient had been admitted to the hospital and that the patient was "on a Lasix drip for severe edema."</p> <p>2. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 4-30-13 at 3:15 PM. The supervising nurse indicated there was no further documentation of contact with either doctor on 4-24-13.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The RN or therapist promptly notifies the physician of any changes that suggests a need to modify the plan of care."</p>						

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N000537	<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 and agency policy review and interview, the agency failed to ensure the registered nurse had provided treatments in accordance with the plan of care in 2 (#s 6 and 12) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on 3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>2. Clinical record number 12 included a</p>	N000537	<p>The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying all orders for wounds and labs and to furnish skilled nursing services in accordance with the plan of care. Clinical Managers will audit 100% of all lab orders X 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Clinical Managers to review all lab results and to physically match the lab order to the lab results, thus ensuring the lab order is present. Both Coders were in-serviced by the Administrator related to always coding in "real time" and including all orders obtained in a 5-day window.</p>	05/30/2013			

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	<p>plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p> <p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per</p>		<p>Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of completion: 5.30.13</p>		

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	<p>the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had notified the physician of a patient's deteriorating condition in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included verbal start of care orders from the patient's primary care physician (PCP) for the certification period 4-13-13 to 6-11-13 that evidenced skilled nursing was to be provided 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 6 weeks. The plan also evidenced physical therapy was to be provided 2 times per week for 8 weeks and occupational therapy 1 time per week for 1 week then 2 times per week for 6</p>	N000546	The RN involved in the deficiency received disciplinary action by management on 5.17.13.All RN's will be in-serviced by the Administrator or designee related to professional staff management, prompt notification to physician to changes that occur requiring the need to alter the plan of care. RN's are required to contact management for assistance if the physician does not return calls timely or if the nurse experiences difficulty in reaching the physician.All RN's will be in-serviced by the Administrator or designee related to the use of the new case conference form. Clinical Managers and team will discuss weekly at case conference all patients who have experienced any exacerbation or change in condition, so that all parties are aware of the changes.Administrator or desingee will audit 100% of all case conference agendas for 30	05/30/2013			

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	<p>weeks. The plan of care evidenced the agency "May accept orders for [cardiologists] who are to address Cardiology issues."</p> <p>A The record included an admission skilled nurse (SN) visit note dated 4-13-13 that identified the patient weighed 226 pounds, was short of breath "with minimal exertion", had a "Mitral valve replacement 3-15.13 and pacemaker placement 3-17-13", and that the patient had "significant peripheral edema. Past surgery includes cardiac surgery."</p> <p>B. A SN visit note dated 4-15-13 evidenced the patient had "plus 2 pitting edema in bilateral lower legs and feet. Patient is on oxygen at 1.5 L."</p> <p>C. A SN visit note dated 4-18-13 evidenced the patient had 3 plus pitting edema in the right and left feet and that the patient had "retraction / labored breathing . . . unable to lie flat and sleeps in chair with feet elevated." The note evidenced further the patient's weight was 238.1.</p> <p>1.) The note states, "Today [the patient's] respirations are labored and [the patient] has 3+ pitting edema to tops of feet. [The patient's spouse] called cardiologist to request increase in</p>		<p>days, then 10% for 3 months and then PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>		

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	<p>diuretic."</p> <p>2.) The record failed to evidence the registered nurse had contacted either the PCP or the cardiologist to inform them of the patient's increase in edema and increased difficulty breathing.</p> <p>D. A SN visit note dated 4-19-13 evidenced the patient had continued 3+ pitting edema in both feet. The note states, "pt [patient] is to take an extra dose [Lasix] today due to increased edema." The note states further, "SN made 2 attempts at venipuncture once to each AC for labs. SN contacted [name of doctor] regarding inability to get blood instructed to send pt to lab for blood draw today due to increased edema."</p> <p>E. A SN visit note dated 4-22-13 evidenced the patient's respiratory rate was 24, the patient was short of breath with minimal exertion, and was "anxious due to dyspnea." The note evidenced the patient continued with 3+ pitting edema in the feet, and that "accessory muscles used" for breathing.</p> <p>1.) The 4-22-13 SN visit note states, "Wife reports pt more dyspneic over the weekend and [the patient] is more labored today that at last visit 3 days ago. Respirations are labored and shallow</p>				

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	<p>at 27/minute. Pulse ox is 91% on 1/25 liters per nasal cannula . . . Pt instructed to splint ribs with a pillow and to take deep breaths . . . to use oxygen at all times . . . Wife instructed on counting respirations and instructed to call SN if rate exceeded 30/minute . . . Pt has 3+ to 4+ pitting edema to bilateral feet and ankles. SN instructed [the patient] to keep feet elevated at all times and to continue with prescribed medications for edema."</p> <p>2.) The record failed to evidence the registered nurse had contacted the PCP or the cardiologist with the information the patient continued to experience difficulties.</p> <p>F. The record evidenced the SN did not contact the physician until the next day on 4-23-13. A "Case Communication Note" dated 4-23-13 evidenced the SN had contacted the cardiologist and left a voice mail message for the nurse. The note indicated the nurse returned the call later in the afternoon and the cardiologist had recommended a "pulmonology consult." The note evidenced the SN had also contacted the patient's PCP. The PCP's nurse stated, "[The PCP] had not seen this pt since well before he went into the hospital and had not been informed of events that transpired in the interim, so he</p>				

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	<p>felt uncomfortable assuming responsibility for home care supervision. She also stated that cardiologist had ordered home care and therapies without speaking with [primary care physician]."</p> <p>G. A SN visit note dated 4-24-13 states, "pedal pulses weak . . . 3+ to 4+ pitting edema . . . more labored respirations that last visit 2 days ago; shallow, rapid and using shoulder muscles to breathe."</p> <p>1.) A "Case Communication Report" dated 4-24-13 states, "Pt feeling worse today than at visit 2 days ago. Respirations are more labored and he is using accessory muscles to breathe. Lungs are clear, diminished and pulse ox [oximeter] is 90% on usual oxygen flow rate of 1.25 liters / minute. [The patient] is pale and states slept poorly. States poor appetite and too tired to eat. Becomes noticeably dyspneic with walking short distances. Bilateral pedal edema 3-4+ and pitting. Urns [sic] amber in color and wt [weight] is same past 3 days with no improvement despite increased diuretic use. Skin turgor is greater than 3 at hands and less than 3 at forearms. Pt is dyspneic with talking. When SN arrive, pt stated that when [spouse] returns home, is taking him to the ER for evaluation at [cardiologist's] instruction this morning.</p>				

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	<p>Pt reports that [spouse] spoke with [PCP] office this morning and they are aware of [the patient's] current condition and that [the patient] is going to the ER."</p> <p>2.) The record failed to evidence the registered nurse had notified the physician of the patient's continued decline and difficulty breathing.</p> <p>3.) The "Case Communication Report" dated 4-24-13 evidenced the patient's spouse had called and informed the agency the patient had been admitted to the hospital and that the patient was "on a Lasix drip for severe edema."</p> <p>2. The supervising nurse, employee B, was unable to provide any additional documentation and/or information when asked on 4-30-13 at 3:15 PM. The supervising nurse indicated there was no further documentation of contact with either doctor on 4-24-13.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The RN or therapist promptly notifies the physician of any changes that suggests a need to modify the plan of care."</p>				

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N000596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs as required by 410 IAC 17-14-1 (h)(3) and urinary catheter care as a part of toileting</p>	N000596	HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. The	05/30/2013

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	and elimination as required by 410 IAC 17-14-1 (h)(9)(F).  2. The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the individual had been evaluated for the competent performance of vital signs or urinary catheter care.		agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits.Date of Completion: 5.30.13		

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N000608	<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 and agency policy review and interview, the agency failed to ensure clinical notes had been incorporated into the medical record weekly as required by the agency's policy in 1 (# 6) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record 6 included a plan of care established by the physician for the certification period 3-15-13 to 5-13-13 that identified occupational therapy (OT) was to be provided 1 time per week for 1</p>	N000608	<p>Administrator and DON revised current policy #3013 related to timely filing to state that all paperwork is to be entered/entered into patient's chart within 14 days. The agency added a part-time receptionist to one branch (Huntingburg, IN) to better aide in timely filing. As of 5.30.13, all filing is current at each location, with staffing in place to ensure this. Therapy Manager has new process in place to ensure timely receipt and filing of therapy notes. Office Manager has new process in place with office personnel to ensure timely processing of paperwork, mailing to physicians, and filing on charts. Therapy</p>	05/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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	<p>week then 2 times per week for 8 weeks and that physical therapy (PT) was to be provided 1 time per week for 1 week then 2 times per week for 5 weeks.</p> <p>A. The record failed to include clinical notes for PT services provided on 3-15-13, 3-19-13, 3-22-13, 3-27-13, 3-29-13, 4-1-13, 4-3-13, and 4-9-13. The branch clinical manager, employee O, provided clinical notes for the PT services when asked on 4-25-13 at 10:25 AM. The manager stated, "I don't have a reason why the notes were not filed in the chart."</p> <p>B. The record failed to include clinical notes for OT services provided on 3-15-13, 3-18-13, 3-20-13, 3-25-13, 3-29-13, and 4-3-13. The branch clinical manager, employee O, provided clinical notes for the OT services when asked on 4-25-13 at 10:25 AM. The manager stated, "I don't have a reason why the notes were not filed in the chart."</p> <p>2. The agency's 2009 "Confidentiality" policy number 3013 states, "Original records can be initiated outside the Vibrant! office, but must be submitted to the corporate office within forty-eight (48) hours and incorporated in the clinical record weekly."</p>		<p>Manager has been in-serviced on new process on 5.14.13. Appropriate office staff have been in-serviced on new process on 5.13.13. Receptionists/filers at each location will be in-serviced on new processes by 5.30.13. Administrator or designee will audit 100% of filing weekly, using the audit tool, to ensure timely filing for 3 months at each location and PRN as needed to ensure compliance. The agency's QA team will meet quarterly to determine the agency's level of compliance and recommend necessity of ongoing audits. Date of Completion: 5.30.13</p>		

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