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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/15/2012 | |
| NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902 | | | |
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| G0000 | <p>This visit was an initial Home Health federal Medicaid certification survey.</p> <p>Survey dates: 8/13/12 to 8/15/12</p> <p>Facility #: 012928</p> <p>Medicaid vendor #: NA</p> <p>Surveyor: Bridget Boston, RN , PHNS</p> <p>Census: 10 Home visits 2</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 21, 2012</p> | | | G0000 | | | |

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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| G0158 | <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled care provided followed a written plan of care and physician order for 1 of 1 pediatric patient record reviewed with the potential to affect all the agency's patients. (# 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record # 7, a pediatric patient, SOC 7/10/12, evidenced a comprehensive assessment dated 7/10/12 that stated, "MD order to wear brace times 2 weeks ... Educated caregiver [family member] regarding ROM [range of motion]." The clinical record failed to evidence an order for a brace and for range of motion. <p>On August 15, 2012, at 6:15 PM, the director of nursing indicated the brace was a splint placed on the child on 7/10/12 and confirmed there was not an order for the brace and for specific range of motion, type, and frequency.</p> <ol style="list-style-type: none"> The policy titled "Home Care Program - Client Assessment" review date 5/6/12 | G0158 | <p>G158-(1)Initiate a policy and procedure for admitting and assessing patients using the Oasis comprehensive assessment will be carried over to the 485 plan of care policy which will be reviewed and signed by the physician every 60 days and as needed for condition changes. A copy of the current plan of care will be kept in folder in Director of Nursing office and will be used during nursing visits to review and check off goals. All nurses will be trained to follow this procedure. (2) Scott's Home Healthcare will prevent this from happening again by the Administrator RN. Auditing of all clinical records quarterly for evidence that all physician orders are included on plan of care, and that they are carried over from Oasis onto plan of care, and are accurately initiated. (3) The Administrator RN, will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. (4) This deficiency will be corrected by 8/24/2012</p> | 08/24/2012 | | | |

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| | and effective date 7/20/12 stated, "Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans." | | | |

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| G0159 | <p>484.18(a) PLAN OF CARE</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, interview, and policy review, the agency failed to ensure an individualized plan of care was developed and included all the required elements in 10 of 10 clinical records (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 1, start of care 7/6/12, included a comprehensive assessment dated 7/6/12 that identified at OASIS item M 1210 mild to moderate hearing impairment and at M 1300 was at risk for developing pressure ulcers. The plan of care for the certification period 7/6/12 through 9/3/12, with the admission diagnosis of angina, failed to evidence interventions and measurable patient specific goals for the risks identified during the comprehensive assessment and</p> | G0159 | <p>G159--(1)Initiate a policy and procedure for admitting and assessing patients using the Oasis comprehensive assessment will be carried over to the 485 plan of care policy which will be reviewed and signed by the physician every 60 days and as needed for condition changes. A copy of the current plan of care will be kept in folder in Director of Nursing office and will be used during nursing visits to review and check off goals. All nurses will be trained to follow this procedure. Initiate a training program for nurses, instructed by Administrator RN, which will include teaching how to develop and implement a patient plan of care using patient diagnosis 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</p> | 08/24/2012 | | | |

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| | <p>the patients functional limitations and admission diagnosis.</p> <p>2. Clinical record # 2, start of care 7/5/12, included a comprehensive assessment dated 7/5/12 which identified and stated, "Disease Management Problems - Needs education on diet, exercise, insulin use, and foot care." The plan of care for the certification period 7/5/12 through 9/2/12, with admission diagnosis diabetes mellitus, failed to evidence interventions and patient specific measurable goals for the needs identified on the assessment.</p> <p>3. Clinical record # 3, start of care 7/12/12, included the comprehensive assessment dated 7/12/12 which identified the patient was experiencing pain of the head and neck rated at an 8 out of 10 during the time of the assessment. The plan of care for the certification period 7/12/12 through 9/9/12, admission diagnosis degenerative joint disease, failed to evidence interventions and measurable patient specific goals for the needs identified on the comprehensive assessment and admission diagnosis.</p> <p>4. Clinical record # 4, start of care 7/11/12, included a comprehensive assessment dated 7/11/12 which identified the patient's deficits were: 1) hard of</p> | | <p>against injury, instructions for timely discharge or referral, any other appropriate items. We will also be using care plan pathways in this training (2) The Administrator RN will instruct all nurses on establishing and implementing a plan of care before skilled nurse visits begin. (3) The Administrator RN will be responsible for making sure these are completed. (4) This deficiency will be completed by 8/24/2012</p> | | | | |

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| | <p>hearing bilaterally, 2) aphasic - Expressive, and 3) at OASIS element 1740 stated "memory deficit, failure to recognize familiar persons / places, inability to recall events of the past 24 hours, significant memory loss so that supervision is required." The plan of care for the certification period 7/11/12 through 9/8/12, with admission diagnosis Huntington's Chorea, failed to evidence interventions and measurable patient specific goals related to the admission diagnosis and taking into consideration the deficits identified during comprehensive assessment.</p> <p>5. Clinical record # 5, start of care 7/9/12, included a comprehensive assessment dated 7/9/12 that identified a fall risk of 15 and stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to area of risk, 2. refer to physical therapy and / or occupational therapy, 3. Monitor for areas of risk to reduce falls, 4. Reassess the patient." The plan of care for the certification period 7/9/12 through 9/6/12, with admission diagnosis of COPD, failed to evidence interventions and measurable patient specific goals related to the admission diagnosis and the identified needs of the patient.</p> | | | |

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| | <p>6. Clinical record # 6, start of care 7/10/12, included a comprehensive assessment dated 7/10/12 that identified at the time of the assessment, the patient had a blood glucose level of 485, was assessed to be at a high nutritional risk, and stated, "Needs education on diabetic foot care ... Demonstrates independence in diabetic foot care / diet by 9/7/12." The plan of care for the certification period 7/10/12 through 9/7/12, with admission diagnosis of diabetes mellitus, failed to evidence interventions and specific measurable patient goals for the needs identified on the assessment and related to the admission diagnosis.</p> <p>7. Clinical record # 7, a pediatric patient and start of care 7/10/12, included a comprehensive assessment that stated, "To wear brace X [times] 2 weeks ... educated patient's caregiver [name] regarding ROM [range of motion]." The plan of care for the certification period 7/10/12 through 9/7/12, with admission diagnosis fractured right ulna, failed to evidence an order for range of motion of any kind, interventions, and measurable patient specific goals related to the admission diagnosis.</p> <p>8. Clinical record # 8, start of care 7/15/12, included a comprehensive</p> | | | |

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| | <p>assessment which identified the patient had "1) a fall risk with score of 30, 2) bilateral weakness of lower extremities, 3) incontinence with urgency, 4) missing 3 teeth, 5) a nutritional score identified 'moderate risk,' 6) experienced dyspnea with minimal exertion, and 7) had a non productive cough." The plan of care for the certification period 7/15/12 through 9/12/12, with diagnosis Multiple Sclerosis, included one measurable goal that stated, "Skin integrity will be maintained by no red or open areas." The plan of care failed to evidence interventions and measurable patient specific goals related to all the needs identified on the comprehensive assessment.</p> <p>9. Clinical record # 9, start of care 7/19/12, included a comprehensive assessment dated 7/19/12 that indicated the reason for home care was "osteoporosis, educate instruct disease process," identified the patient was independent with medication administration, and stated as goals to be achieved, "Demonstrate competence in following medical regime." As the service to be provided while on care, the plan of care stated, "Skilled nurse for assessment of osteoporosis." The plan of care for the certification period 7/19/12 through 9/16/12, with admission</p> | | | |

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| | <p>diagnosis of osteoporosis, failed to evidence patient specific and measurable goals related to the admission diagnosis.</p> <p>10. Clinical record # 10, start of care 7/9/12, included the plan of care for the certification period 7/9/12 through 9/6/12, with admission diagnosis of diverticulosis, that failed to evidence patient specific and measurable goals.</p> <p>11. The policy titled "Home Care Program - Client Assessment" reviewed date 5/6/12 and effective date 7/20/12 stated, "Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans."</p> <p>12. On August 15, 2012, at 6:45 PM, the director of nursing indicated measurable goals and specific interventions to meet a patient specific goal were not found on the individual plans of care for the patients reviewed, #1 through 10.</p> | | | |

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| G0331 | <p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse made the initial assessment visit after the referral for home care to determine immediate care needs in 9 (#s 1, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 clinical records reviewed of patients admitted for skilled home care services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record # 1, start of care (SOC) 7/6/12, evidenced a referral to home care dated 7/2/12 and a comprehensive assessment dated 7/6/12. The record failed to evidence an initial assessment was completed to identify immediate needs. Clinical record # 3, SOC 7/12/12, evidenced a referral to home care dated 7/3/12 and a comprehensive assessment dated 7/12/12. The record failed to evidence an initial assessment to identify the patients immediate needs. | G0331 | <p>G331-(1) We are going to train all agency staff that once a referral is made contact will be made with the patient within 24 hours and admission assessment within 48 hours.</p> <p>(2) Training will be given, all staff during orientation process.</p> <p>(3) The administrative nurse will ensure that this training is implemented.</p> <p>(4) This deficiency will be corrected by 8/24/2012</p> | 08/24/2012 | | | |

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| | <p>3. Clinical record # 4, SOC 7/11/12, evidenced a referral to home care dated 7/3/12 and the comprehensive assessment dated 7/11/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>4. Clinical record # 5, SOC 7/9/12, evidenced a referral to home care dated 7/3/12 and a comprehensive assessment dated 7/9/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>5. Clinical record # 6, SOC 7/10/12, evidenced a referral to home care dated 7/6/12 and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>6. Clinical record # 7, SOC 7/10/12, evidenced a referral and physician's verbal order for home care dated 7/6/12 and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>7. Clinical record # 8, SOC 7/15/12, evidenced a referral to home care dated 7/5/12 and a comprehensive assessment dated 7/15/12. The record failed to evidence an initial assessment to identify</p> | | | |

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| | <p>the patients immediate needs.</p> <p>8. Clinical record # 9, SOC 7/19/12, evidenced a referral to home care dated 7/9/12 and a comprehensive assessment dated 7/19/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>9. Clinical record # 10, SOC 7/9/12, evidenced a referral and physician's verbal order for home care dated 7/5/12, and a comprehensive assessment dated 7/9/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>10. On 8/15/12 at 5:21 PM, the director of nursing indicated the agency contacted the patients and offered home care services; they wrote the referrals and spaced out the planned admissions so the director of nursing did not have to do them all at once as the administrator had to return to another job. The administrator and director of nursing both indicated they were aware that an initial assessment was required within 48 hours of a referral or physician's order.</p> <p>11. The policy titled Home Care Program" reviewed date 5/6/12 and effective date 7/20/12 stated, "Purpose: to conduct an assessment appropriate to the</p> | | | | | | |

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| | home care service provided. to base the plan of care on initial and ongoing assessments. To identify client and caregiver problems and needs. ... The client is contacted within 24 hours of referral order and the client / evaluation is completed within 72 hours of the referral order." | | | |

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| G0332 | <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure an initial assessment was completed within 48 hours of the receipt of the referral for home care or the physician ordered start of care 9 (#'s 1, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 clinical records reviewed of patients admitted for skilled home care services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record # 1, start of care (SOC) 7/6/12, evidenced a referral to home care dated 7/2/12, a physician order to assess for home healthcare services dated 7/5/12, and a comprehensive assessment dated 7/6/12. The record failed to evidence an initial assessment was completed within 48 hours to identify immediate needs. Clinical record # 3, SOC 7/12/12, evidenced a referral to home care dated 7/3/12, a physician order to assess for home healthcare dated 7/9/12, and a comprehensive assessment dated 7/12/12. The record failed to evidence an initial assessment to identify the patients | G0332 | <p>--(1) We are going to train all agency staff that once a referral is made contact will be made with the patient within 24 hours and admission assessment within 48 hours.</p> <p>(2) Training will be given, all staff during orientation process.</p> <p>(3) The administrative nurse will ensure that this training is implemented.</p> <p>(4) This deficiency will be corrected by 8/24/2012</p> | 08/24/2012 | | | |

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| | <p>immediate needs within 48 hours of the referral and the physician order.</p> <p>3. Clinical record # 4, SOC 7/11/12, evidenced a referral to home care dated 7/3/12, a physician order to assess for home health care dated 7/5/12, and the comprehensive assessment dated 7/11/12. The record failed to evidence an initial assessment to identify the patients immediate needs within 48 hours of the referral and the physician order.</p> <p>4. Clinical record # 5, SOC 7/9/12, evidenced a referral to home care dated 7/3/12. a physician order dated 7/5/12 to assess for home healthcare, and a comprehensive assessment dated 7/9/12. The record failed to evidence an initial assessment to identify the patients immediate needs was completed within 48 hours of the referral and the physician order.</p> <p>5. Clinical record # 6, SOC 7/10/12, evidenced a referral to home care and a physician order for an evaluation dated 7/6/12, and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs with in 48 hours.</p> <p>6. Clinical record # 7, SOC 7/10/12,</p> | | | |

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| | <p>evidenced a referral and physician's verbal order for home care dated 7/6/12 and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs with in 48 hours. (The dates for #7 are identical to 6.)</p> <p>7. Clinical record # 8, SOC 7/15/12, evidenced a referral to home care dated 7/5/12, a physician order for an assessment for home healthcare services was dated 7/6/12, and a comprehensive assessment dated 7/15/12. The record failed to evidence an initial assessment to identify the patients immediate needs with in 48 hours of the referral and the physician order.</p> <p>8. Clinical record # 9, SOC 7/19/12, evidenced a referral to home care dated 7/9/12, a physician order for evaluation dated 7/10/12, and a comprehensive assessment dated 7/19/12. The record failed to evidence an initial assessment to identify the patients immediate needs with in 48 hours of the referral and the physician order.</p> <p>9. Clinical record # 10, SOC 7/9/12, evidenced a referral and physician's order for an assessment for home healthcare services dated 7/5/12, and a comprehensive assessment dated 7/9/12.</p> | | | |

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| | <p>The record failed to evidence an initial assessment to identify the patients immediate needs with in 48 hours of the referral and the physician order.</p> <p>10. On 8/15/12 at 5:21 PM, the director of nursing indicated the agency contacted the patients and offered home care services; then they wrote the referrals and spaced out the planned admissions. The administrator and director of nursing both indicated they were aware that an initial assessment was required within 48 hours of a referral and physician's order and indicated the records did not evidence the physician was notified of the planned delay of the initial assessments.</p> <p>11. The policy titled Home Care Program" reviewed date 5/6/12 and effective date 7/20/12 stated, "Purpose: to conduct an assessment appropriate to the home care service provided. to base the plan of care on initial and ongoing assessments. To identify client and caregiver problems and needs. ... The client is contacted within 24 hours of referral order and the client / evaluation is completed within 72 hours of the referral order."</p> | | | | | | |

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| N0522 | <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:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled care provided followed a written plan of care and physician order for 1 of 1 pediatric patient record reviewed with the potential to affect all the agency's patients. (# 7)</p> <p>Findings include:</p> <p>1. Clinical record # 7, a pediatric patient, SOC 7/10/12, evidenced a comprehensive assessment dated 7/10/12 that stated, "MD order to wear brace times 2 weeks ... Educated caregiver [family member] regarding ROM [range of motion]." The clinical record failed to evidence an order for a brace and for range of motion.</p> <p>On August 15, 2012, at 6:15 PM, the director of nursing indicated the brace was a splint placed on the child on 7/10/12 and confirmed there was not an order for the brace and for specific range of motion, type, and frequency.</p> <p>2. The policy titled "Home Care Program - Client Assessment" review date 5/6/12</p> | N0522 | <p>--(1)Initiate a policy and procedure for admitting and assessing patients using the Oasis comprehensive assessment will be carried over to the 485 plan of care policy which will be reviewed and signed by the physician every 60 days and as needed for condition changes. A copy of the current plan of care will be kept in folder in Director of Nursing office and will be used during nursing visits to review and check off goals. All nurses will be trained to follow this procedure. This policy and procedure will also insure that the skilled care provided to patient will follow a written plan of care and physicians orders. (2) Scott's Home Healthcare will prevent this from happening again by the Administrator RN. Auditing of all clinical records quarterly for evidence that all physician orders are included on plan of care, and that they are carried over from Oasis onto plan of care, and are accurately initiated. (3) The Administrator RN, will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. (4) This deficiency will be corrected by 8/24/2012</p> | 08/24/2012 | | | |

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| | and effective date 7/20/12 stated, "Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans." | | | | |

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| N0524 | <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> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure an individualized plan of care was developed and included all the required elements in 10 of 10 clinical records (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 1, start of care</p> | N0524 | <p>---(1)Initiate a policy and procedure for admitting and assessing patients using the Oasis comprehensive assessment will be carried over to the 485 plan of care policy which will be reviewed and signed by the physician every 60 days and as needed for condition changes. A copy of the current plan of care will be kept in folder in Director of Nursing office and will be used during nursing visits to review and check off goals. All nurses will be trained to follow this procedure.</p> | 08/24/2012 | | | |

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| | <p>7/6/12, included a comprehensive assessment dated 7/6/12 that identified at OASIS item M 1210 mild to moderate hearing impairment and at M 1300 was at risk for developing pressure ulcers. The plan of care for the certification period 7/6/12 through 9/3/12, with the admission diagnosis of angina, failed to evidence interventions and measurable patient specific goals for the risks identified during the comprehensive assessment and the patients functional limitations and admission diagnosis.</p> <p>2. Clinical record # 2, start of care 7/5/12, included a comprehensive assessment dated 7/5/12 which identified and stated, "Disease Management Problems - Needs education on diet, exercise, insulin use, and foot care." The plan of care for the certification period 7/5/12 through 9/2/12, with admission diagnosis diabetes mellitus, failed to evidence interventions and patient specific measurable goals for the needs identified on the assessment.</p> <p>3. Clinical record # 3, start of care 7/12/12, included the comprehensive assessment dated 7/12/12 which identified the patient was experiencing pain of the head and neck rated at an 8 out of 10 during the time of the assessment. The plan of care for the certification period</p> | | <p>Initiate a training program for nurses, instructed by Administrator RN, which will include teaching how to develop and implement a patient plan of care using patient diagnosis 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, any other appropriate items. We will also be using care plan pathways in this training (2) The Administrator RN will instruct all nurses on establishing and implementing a plan of care before skilled nurse visits begin. (3) The Administrator RN will be responsible for making sure these are completed. (4) This deficiency will be completed by 8/24/2012</p> | | | | |

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| | <p>7/12/12 through 9/9/12, admission diagnosis degenerative joint disease, failed to evidence interventions and measurable patient specific goals for the needs identified on the comprehensive assessment and admission diagnosis.</p> <p>4. Clinical record # 4, start of care 7/11/12, included a comprehensive assessment dated 7/11/12 which identified the patient's deficits were: 1) hard of hearing bilaterally, 2) aphasic - Expressive, and 3) at OASIS element 1740 stated "memory deficit, failure to recognize familiar persons / places, inability to recall events of the past 24 hours, significant memory loss so that supervision is required." The plan of care for the certification period 7/11/12 through 9/8/12, with admission diagnosis Huntington's Chorea, failed to evidence interventions and measurable patient specific goals related to the admission diagnosis and taking into consideration the deficits identified during comprehensive assessment.</p> <p>5. Clinical record # 5, start of care 7/9/12, included a comprehensive assessment dated 7/9/12 that identified a fall risk of 15 and stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention</p> | | | | | | |

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| | <p>strategies specific to area of risk, 2. refer to physical therapy and / or occupational therapy, 3. Monitor for areas of risk to reduce falls, 4. Reassess the patient." The plan of care for the certification period 7/9/12 through 9/6/12, with admission diagnosis of COPD, failed to evidence interventions and measurable patient specific goals related to the admission diagnosis and the identified needs of the patient.</p> <p>6. Clinical record # 6, start of care 7/10/12, included a comprehensive assessment dated 7/10/12 that identified at the time of the assessment, the patient had a blood glucose level of 485, was assessed to be at a high nutritional risk, and stated, "Needs education on diabetic foot care ... Demonstrates independence in diabetic foot care / diet by 9/7/12." The plan of care for the certification period 7/10/12 through 9/7/12, with admission diagnosis of diabetes mellitus, failed to evidence interventions and specific measurable patient goals for the needs identified on the assessment and related to the admission diagnosis.</p> <p>7. Clinical record # 7, a pediatric patient and start of care 7/10/12, included a comprehensive assessment that stated, "To wear brace X [times] 2 weeks ... educated patient's caregiver [name]"</p> | | | |

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| | <p>regarding ROM [range of motion]." The plan of care for the certification period 7/10/12 through 9/7/12, with admission diagnosis fractured right ulna, failed to evidence an order for range of motion of any kind, interventions, and measurable patient specific goals related to the admission diagnosis.</p> <p>8. Clinical record # 8, start of care 7/15/12, included a comprehensive assessment which identified the patient had "1) a fall risk with score of 30, 2) bilateral weakness of lower extremities, 3) incontinence with urgency, 4) missing 3 teeth, 5) a nutritional score identified 'moderate risk,' 6) experienced dyspnea with minimal exertion, and 7) had a non productive cough." The plan of care for the certification period 7/15/12 through 9/12/12, with diagnosis Multiple Sclerosis, included one measurable goal that stated, "Skin integrity will be maintained by no red or open areas." The plan of care failed to evidence interventions and measurable patient specific goals related to all the needs identified on the comprehensive assessment.</p> <p>9. Clinical record # 9, start of care 7/19/12, included a comprehensive assessment dated 7/19/12 that indicated the reason for home care was</p> | | | |

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| | <p>"osteoporosis, educate instruct disease process," identified the patient was independent with medication administration, and stated as goals to be achieved, "Demonstrate competence in following medical regime." As the service to be provided while on care, the plan of care stated, "Skilled nurse for assessment of osteoporosis." The plan of care for the certification period 7/19/12 through 9/16/12, with admission diagnosis of osteoporosis, failed to evidence patient specific and measurable goals related to the admission diagnosis.</p> <p>10. Clinical record # 10, start of care 7/9/12, included the plan of care for the certification period 7/9/12 through 9/6/12, with admission diagnosis of diverticulosis, that failed to evidence patient specific and measurable goals.</p> <p>11. The policy titled "Home Care Program - Client Assessment" reviewed date 5/6/12 and effective date 7/20/12 stated, "Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans."</p> | | | | | | |

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| | 12. On August 15, 2012, at 6:45 PM, the director of nursing indicated measurable goals and specific interventions to meet a patient specific goal were not found on the individual plans of care for the patients reviewed, #1 through 10. | | | |

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| N0540 | <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse made the initial assessment visit after the referral for home care to determine immediate care needs in 9 (#s 1, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 clinical records reviewed of patients admitted for skilled home care services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record # 1, start of care (SOC) 7/6/12, evidenced a referral to home care dated 7/2/12 and a comprehensive assessment dated 7/6/12. The record failed to evidence an initial assessment was completed to identify immediate needs. Clinical record # 3, SOC 7/12/12, evidenced a referral to home care dated 7/3/12 and a comprehensive assessment dated 7/12/12. The record failed to evidence an initial assessment to identify the patients immediate needs. | N0540 | <p>--(1) We are going to train all agency staff that once a referral is made contact will be made with the patient within 24 hours and admission assessment within 48 hours. (2) Training will be given, all staff during orientation process. (3) The administrative nurse will ensure that this training is implemented. (4) This deficiency will be corrected by 8/24/2012</p> | 08/24/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/15/2012 | |
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| NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>3. Clinical record # 4, SOC 7/11/12, evidenced a referral to home care dated 7/3/12 and the comprehensive assessment dated 7/11/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>4. Clinical record # 5, SOC 7/9/12, evidenced a referral to home care dated 7/3/12 and a comprehensive assessment dated 7/9/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>5. Clinical record # 6, SOC 7/10/12, evidenced a referral to home care dated 7/6/12 and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>6. Clinical record # 7, SOC 7/10/12, evidenced a referral and physician's verbal order for home care dated 7/6/12 and a comprehensive assessment dated 7/10/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>7. Clinical record # 8, SOC 7/15/12, evidenced a referral to home care dated 7/5/12 and a comprehensive assessment dated 7/15/12. The record failed to evidence an initial assessment to identify</p> | | | | | | |

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| | <p>the patients immediate needs.</p> <p>8. Clinical record # 9, SOC 7/19/12, evidenced a referral to home care dated 7/9/12 and a comprehensive assessment dated 7/19/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>9. Clinical record # 10, SOC 7/9/12, evidenced a referral and physician's verbal order for home care dated 7/5/12, and a comprehensive assessment dated 7/9/12. The record failed to evidence an initial assessment to identify the patients immediate needs.</p> <p>10. On 8/15/12 at 5:21 PM, the director of nursing indicated the agency contacted the patients and offered home care services; they wrote the referrals and spaced out the planned admissions so the director of nursing did not have to do them all at once as the administrator had to return to another job. The administrator and director of nursing both indicated they were aware that an initial assessment was required within 48 hours of a referral or physician's order.</p> <p>11. The policy titled Home Care Program" reviewed date 5/6/12 and effective date 7/20/12 stated, "Purpose: to conduct an assessment appropriate to the</p> | | | | | | |

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|--------------------------|--|---------------------|--|----------------------------|
| | home care service provided. to base the plan of care on initial and ongoing assessments. To identify client and caregiver problems and needs. ... The client is contacted within 24 hours of referral order and the client / evaluation is completed within 72 hours of the referral order." | | | |