

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME CARE SERVICES OF VINCENNES IN	STREET ADDRESS, CITY, STATE, ZIP CODE 413 N FIRST ST VINCENNES, IN 47591
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G000000	<p>This was a Federal home health recertification survey.</p> <p>Survey Dates: 1-22-14, 1-23-14, 1-24-14, 1-27-14, 1-28-14, & 1-29-14. Partial extended: 1-22-14 Extended 1-29-14</p> <p>Facility # 005945</p> <p>Medicaid Vendor: 200500550A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Good Samaritan Home Care is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 2-3-14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; 42 CFR 484.32 Therapy Services; and 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>The Administrator and the Manager of Clinical Services were informed of the above-stated preclusion at the exit conference held on 1-29-14 at 3:20 PM.</p>	G000000		

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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G000121	<p>Agency census:</p> <p>155 skilled 17 home health aide only 0 personal services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 3, 2014</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and review of agency policy, the agency failed to ensure staff had provided services in accordance with its own infection control policies and procedures and topical medication application policies and procedures in 5 (#s 2, 4, 5, 6, & 7) of 8 home visit observations completed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. The agency's 3-26-12 "Standard (Universal) Precautions" policy number 33.39 states, "Standards precautions will be followed on all patients."</p>	G000121	G121Mandatory inservices for all Professional/Paraprofessional staff were held on 2-11-14, 2-13-14, 2-14-14 and 2-17-14 by the Director of Clinical Services (DCS) and Educator regarding policy # 33.83 Bag Technique, policy #33.39 Standard (Universal) Precautions, policy #33.900 Hand Hygiene and policy # 33.130 Clinical Equipment Management. Return demonstration of appropriate hand hygiene technique and bag technique demonstration was included. Education for Professional staff regarding policy # 33.713 Topical Ointment/Cream Application and the appropriate application of topical creams and ointments according to the	02/27/2014			

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	<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, nonintact skin, or wound dressings. 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). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . 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</p>		<p>agency policy was also provided. Education packets mailed on 2-17-14 to all Professional/Paraprofessional staff that were unable to attend the inservice. Return demonstration of hand hygiene and bag technique is being individually scheduled with staff unable to attend. To ensure compliance with the above policies and procedures the DCS or designee will conduct 6 home visits per month for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly quality monitoring. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves.</p> <p>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. The agency's 6-15-09 "Topical Ointment/Cream Application" policy number 33.713 states, "Apply topical ointment/cream to client's body part, wearing plastic gloves and using a tongue depressor or a swab."</p> <p>4. Home visit # 2 was completed on 1-23-14 at 1:05 PM to patient number 7 with the registered nurse (RN), employee H. The RN was observed to perform a dressing change to the patient's right hip.</p> <p>A. The RN donned clean gloves and removed the patient's shoes and touched the patient's feet. She charted her findings by touching the keyboard of her computer with gloved hands. The RN failed to remove her gloves and cleanse her hands prior to touching the computer.</p> <p>B. With the same gloves on, the RN then gathered clean supplies to perform</p>						

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	<p>the dressing change. She removed her gloves and washed her hands. She donned clean gloves and gathered more supplies from the patient's home supply. She prepared the supplies on a pad on the bed next to the patient. She cut the Coverall to size in preparation for the dressing change. Without changing her gloves or cleansing her hands, the RN then removed the old dressing. The RN then removed her gloves and cleansed her hands.</p> <p>C. Observation noted the RN's hair hanging down over her gloved hand and touching the gloved hand while the RN completed the dressing change.</p> <p>D. The RN was observed to apply a topical ointment to a reddened area on the patient's sacrum using her gloved finger instead of a tongue depressor or swab.</p> <p>5. Home visit # 4 was completed on 1-23-14 at 3:30 PM to patient number 8 with the RN, employee G. The RN was observed to perform an assessment of the patient.</p> <p>A. The RN was observed to use her stethoscope to listen to the patient's heart, lungs, and abdomen. The RN was observed to place the stethoscope around</p>						

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	<p>her neck without cleansing it creating the potential of the transfer of any disease causing pathogens from the patient's body to the nurse's clothing.</p> <p>B. The RN was observed to apply a diabetic ulcer prevention cream to the patient's buttocks using a her gloved finger instead of a tongue depressor or a swab.</p> <p>6. Home visit # 5 was completed on 1-24-14 at 10 AM to patient number 9 with the home health aide, employee C. The aide was observed to perform a glove change without cleansing her hands after touching the patient.</p> <p>7. Home visit # 6 was completed on 1-24-14 at 11:05 AM to patient number 10 with the home health aide, employee E. The aide was observed to shave the patient without wearing gloves creating the potential for exposure to the patient's blood.</p> <p>A. After washing, rinsing, and drying the patient's buttocks and perineal area with gloves hands, the aide then applied lotion to the patient's knees and upper legs without changing her gloves or cleansing her hands.</p> <p>B. After applying the lotion, the aide</p>			

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	<p>then changed her gloves but failed to cleanse her hands. The aide assisted the patient to pull up the adult diaper. The aide removed her gloves and failed to cleanse her hands and assisted the patient to apply a shirt and pull up the pants.</p> <p>8. Home visit number 7 was completed on 1-24-14 at 12:45 PM to patient number 4 with the RN, employee P. The RN was observed to remove a thermometer covered with a plastic sheath from the patient's mouth without wearing gloves creating the potential for transfer of disease causing organisms from the patient's saliva to the nurse's hand.</p> <p>After removing the thermometer from the patient's mouth, the RN then cleaned her blood pressure cuff and stethoscope with a bleach disposal wipe. The RN then used this same wipe to cleanse her hands and touched her computer keyboard.</p> <p>9. The above-stated findings were discussed with the Manager of Clinical Services, employee B, and the Administrator, employee A, on 1-29-14 at 10 AM. The Manager and the Administrator agreed agency staff had not provided services in accordance with</p>						

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G000143	<p>agency policy.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record review and interview, the registered nurse failed to ensure coordination of services among agency staff and with other health care providers had occurred in 3 (#s 6, 7, and 8) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p>			G000143	<p>G 143Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding coordination of services among agency staff and with other healthcare providers was included. Education was provided regarding policy # 33.24 Plan of Care and Physician Orders. The inservice included appropriate documentation and physician notification if service is refused. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Clarification with physician on 2-18-14. No additional orders received. Patient # 8 - Discharged on 1-28-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to</p>		02/27/2014

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	<p>2. During a home visit to patient number 7, on 1-23-14 at 1:05 PM, with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>3. Clinical record number 8 included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>A. The record failed to evidence the registered nurse had coordinated with the occupational therapist to ensure the</p>		<p>monitor coordination of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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G000144	<p>OT evaluation had been completed.</p> <p>B. The Manager of Clinical Services, employee B, indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review and interview, the registered nurse failed to ensure clinical records evidenced documentation of coordination of services among agency staff and with other health care providers had occurred in 3 (#s 6, 7, and 8) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p>	G000144	G144Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding documentation of coordination of services among agency staff and with other healthcare providers was included. Education was provided regarding policy # 33.24	02/27/2014	

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	<p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>2. During a home visit to patient number 7, on 1-23-14 at 1:05 PM, with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p>				<p>Plan of Care and Physician Orders. The inservice included appropriate documentation and physician notification if service is refused. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Clarification with physician on 2-18-14. No additional orders received. Patient # 8 - Discharged on 1-28-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor coordination of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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G000156	<p>B. The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>3. Clinical record number 8 included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>A. The record failed to evidence the registered nurse had coordinated with the occupational therapist to ensure the OT evaluation had been completed.</p> <p>B. The Manager of Clinical Services, employee B, indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record and agency policy review, observation, and interview, it was determined the agency</p>	G000156	G156See G158, G159, G164 and G165	02/27/2014			

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	<p>failed to maintain compliance with this condition by failing to ensure visits and treatments had been provided as ordered by the physician in 7 of 16 records reviewed creating the potential to affect all of the agency's 172 current patients (See G 158); by failing to ensure plans of care included frequency and duration of visits, who was to perform the treatment, and all medications in 5 of 16 records reviewed creating the potential to affect all of the agency's 172 current patients (See G 159); by failing to ensure agency staff had alerted the physician to changes in the patients' conditions in 2 of 16 records reviewed creating the potential to affect all of the agency's 172 current patients (See G 164); and by failing to ensure drugs and treatments had been provided as ordered by the physician in 5 of 16 records reviewed creating the potential to affect all of the agency's 172 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 484.18 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. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure visits and treatments had been provided as ordered by the physician in 7 (#s 4, 5, 6, 8, 9, 12, & 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 4 identified skilled nurse services had been provided 2 times per week during the certification periods 11-10-13 to 1-8-14 and 1-9-14 to 3-9-14 for dressing changes to a wound on the right hip. <p>A. The record included physician orders dated 11-27-13, 12-11-13, 12-18-13, and 1-9-14 that state, "wash, rinse, peri [with] hibiclens protecting open wound. Irrigate with 20 cc [cubic centimeters] NS [normal saline] piston</p>	G000158	<p>G158Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders. The inservice included information that all visits and treatments, care and services are provided according to current physician orders. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 4 - A wound order clarification was obtained from the physician on 1-28-14 and reviewed with staff. Patient # 5 - Discharged on 2-6-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Physician notified on 12-9-13 of the change in the plan of care for week of 12-7-13, notified on 12-22-13 for week of 12-23-13 and notified 12-29-13 for week of 12-27-13. Clarification on 2-17-14 - change in plan of care</p>	02/27/2014

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME CARE SERVICES OF VINCENNES IN				STREET ADDRESS, CITY, STATE, ZIP CODE 413 N FIRST ST VINCENNES, IN 47591			
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	<p>syringe, Collagen powder to undermining, adaptic, ABD pad, . . . tape."</p> <p>B. Skilled nurse visit notes, dated 11-29-13, 12-2-13, 12-6-13, 12-9-13, 12-13-13, 12-17-13, 12-20-13, 12-23-13, 12-27-13, 12-30-13, 1-3-14, 1-6-14, 1-10-14, 1-13-14, 1-17-14, and 1-20-14, evidenced the dressing change had not been performed as ordered.</p> <p>The notes state, "Cleanse incision with hibiclens, apply collagen powder to wound, cover with adaptic pad and cover with ABD, secure with tape." The notes failed to evidence the peri area had been washed and rinsed, that the wound had been irrigated with normal saline using a piston syringe, and that hibiclens had been used to clean the wound.</p> <p>C. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 1:30 PM, the visit notes did not evidence the dressing change had been completed as ordered.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 1-13-14 to 3-13-14 that identified physical therapy (PT) services were to be provided 4 times per week for 1 week, 5 times per</p>				<p>at patient request. Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Addendum note 2-17-14 to address dressing change. Patient # 12- Discharged 1-2-14. Patient # 16 - Discharged 9-23-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor plan of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>week for 1 week, and 3 times per week for 2 weeks. The plan states, "PT Agency clinicians to address the following . . . DIABETIC FOOT CARE: Assess feet and lower extremities for open areas, injury, or new/increased sensations of numbness/tingling. Instruct on proper diabetic foot care . . . DEPRESSION: Monitor for S/S [signs and symptoms] depression, monitor effectiveness of depression medication, refer to physician if client is experiencing signs of depression."</p> <p>A. PT visit notes, dated 1-14-14, 1-15-14, 1-17-14, 1-20-14, 1-21-14, and 1-23-14, failed to evidence the patient's feet and lower extremities had been assessed or that an assessment had been completed to monitor for any signs and symptoms of depression.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>3. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment states, "PT/INR [blood test] per coagucheck done with results of 1.5 reported to [name of physician] office."</p>			

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	<p>A. The record failed to include an order for the blood test to be completed.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>4. A home visit was made to patient number 8 on 1-23-14 at 3:30 PM with employee G, a registered nurse (RN). The RN was observed to apply a topical diabetic ulcer prevention cream to the patient's buttocks.</p> <p>A. Clinical record number 8 failed to include an order for the diabetic ulcer prevention cream.</p> <p>B. The record included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information regarding an order for the diabetic ulcer prevention cream and</p>			
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	<p>indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>5. Clinical record number 9 included plans of care, established by the physician for the certification periods 11-16-13 to 1-14-14 and 1-15-14 to 3-15-14, that identified home health aide services were to be provided 3 times per week. The record evidenced only 2 home aide visits had been provided the weeks of 12-7-13, 12-22-13, and 12-29-13.</p> <p>A. The plans of care identified skilled nurse services were to be provided every other week throughout the certification periods. The record evidenced skilled nurse services had been provided weekly the weeks of 11-30-13, 12-7-13, and 12-14-13. The record failed to evidence an order for the weekly skilled nurse visits.</p> <p>B. The record included a verbal order, signed and dated by the physical therapist, employee K, on 11-29-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform: 1 Time every other day . . . remove old dressing and discard per policy Cleanse with normal saline apply Normlgel to wound Cover</p>			

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	<p>with Alldress." The record failed to evidence the dressing change had been completed every other day as ordered."</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 11-10-13 to 1-8-14 that states, "SN [skilled nurse] 1 w 9 [1 time per week for 9 weeks]."</p> <p>A. The record failed to evidence a SN visit had been provided the week of 11-10-13.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>7. Clinical record number 16 included an initial comprehensive assessment completed by a physical therapist, employee L, on 8-6-13. The assessment identified the patient had a surgical wound to the right knee with a small amount of serosanguinous drainage and that the tissue around the wound</p>						

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	<p>appeared "red/inflamed." The assessment evidenced the therapist had applied a "dry dressing, 4 X 4, coverall."</p> <p>A. The record failed to include an order for the dressing.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>8. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan . . . All care and services provided is according to current physician orders."</p>				

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G000159	<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 and agency policy review and interview, the agency failed to ensure plans of care included frequency and duration of visits, who was to perform the treatment, and all medications in 5 (#s 2, 6, 7, 9, & 15) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 1-3-14 to 3-3-14. The plan of care identified skilled nursing (SN) services were to be provided. The plan of care states, "SN Agency clinicians to address the following during the episode . . . [vital sign parameters to be reported to the physician] . . . pulse ox prn [oximetry when needed] . . . fall prevention . . .</p>	G000159	G159Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders. Education included information that the Plan of Care is to include frequency and duration of visits, who was to perform the treatment, and all medications. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 2 – Physician clarification order was obtained 2-17-14 for frequency and duration of SN visit. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Physician clarification and medication reconciliation and medication profile updated 2-18-14. Patient # 9 - Physician clarification order obtained 2-17-14. Patient # 15 - Discharged on 10-28-13. To ensure	02/27/2014			

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	<p>pain."</p> <p>The plan of care failed to include the frequency and duration of the SN visits.</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The plan of care established by the physician for the certification period 1-9-14 to 3-9-14 failed to include current medications administered to the patient during the dialysis treatment.</p> <p>A. The administrator, employee A, obtained dialysis orders, including a list of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders identified Epogen 2200 units and Liquacel 1 ounce was administered to the patient during each dialysis treatment 3 times per week. The plan of care states that the patient received Epogen 2000 units 2 times per week and failed to include the Liquacel.</p> <p>B. The dialysis orders identified home medications Nitrostat 0.4 milligrams as needed for chest pain, Dialyvite one tablet daily, Synthroid 112 micrograms, and Milk of Magnesia 30 milliliters daily as needed for</p>		<p>compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor plan of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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	<p>constipation had been ordered. The plan of care failed to include the Nitrostat, the Diallyvite and the Milk of Magnesia. The plan of care evidenced Synthroid 100 micrograms daily.</p> <p>3. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays.</p> <p>A. The plan of care, established by the physician for the certification period 12-25-13 to 2-24-14, failed to include medications administered to the patient during the dialysis treatment and failed to include all home medications.</p> <p>B. The administrator, employee A, obtained dialysis orders, including a list of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders indicated Epogen 2200 units was administered to the patient 3 times per week during the dialysis treatment and that Venofer 50 milligrams was administered 1 time per week. The plan of care failed to include the Epogen and Venofer.</p>						

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	<p>C. The dialysis orders evidenced Labetalol 20 milligrams had been ordered intravenously as needed for blood pressure problems, Lidocaine 1% topically to needle insertion sites, and nitoglycerin 0.4 milligrams as needed for chest pain had been ordered as needed. The plan of care failed to include these medications.</p> <p>4. Clinical record number 9 included an update to the plan of care, a verbal order dated 12-3-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform 1 Time Every Other Day. Remove old dressing and discard per policy. Cleanse with normal saline. Apply Normlgel to wound. Cover with Alldress."</p> <p>The order failed to evidence who was to perform the dressing change and how often visits were to be made to complete the dressing change.</p> <p>5. Clinical record number 15 included an update to the plan of care, a verbal order dated 9-5-13, that states, "SN Wound: anterior - right lateral calf skin tear . . . Perform: 1 time per day."</p> <p>The record failed to evidence who was to perform the dressing change and</p>						

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G000164	<p>how often visits were to be made to complete the dressing change.</p> <p>6. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and on 1-29-14 at 12:40 PM.</p> <p>7. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The plan of care should be based upon a current assessment of the client's needs for care. The plan of care must include . . . types of services . . . frequency and duration of visits . . . all medications, all treatments."</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure agency staff had alerted the physician to changes in the patients' conditions in 2 (#s 3 and 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p>	G000164	G 164Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders and policy # 33.17 Medical Supervision. Education included information that agency staff are to notify the physician with any change in condition. Educational packets mailed to all Professional staff that were	02/27/2014

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	<p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-13-13 to 2-10-14. The plan of care states, "SN to instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p> <p>A. The record failed to evidence the nurse had notified the physician of the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant with the ordered diet and had blood glucose reading above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non compliance" with the prescribed diet and that the patient's blood sugar reading was 209. The note states, "Patient states</p>		<p>unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 16 – Discharged 9-23-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor physician notification of a change in condition for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p> <p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p> <p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p> <p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt doesn't follow diet."</p> <p>2. Clinical record number 16 included an initial comprehensive assessment</p>						

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G000165	<p>completed by the physical therapist, employee L, on 8-6-13. The assessment identifies the patient has a surgical wound to the right knee with a small amount of serosanguinous drainage and that the tissue around the wound appears "red/inflamed." The assessment evidenced the therapist had applied a "dry dressing, 4 X 4, coverall."</p> <p>The record failed to evidence the physical therapist had notified the physician about the pressure area and had obtained ordered for the dressing change.</p> <p>3. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>4. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.</p>			

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	<p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure drugs and treatments had been provided as ordered by the physician in 5 (#s 4, 6, 8, 9, & 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 identified skilled nurse services had been provided 2 times per week during the certification periods 11-10-13 to 1-8-14 and 1-9-14 to 3-9-14 for dressing changes to a wound on the right hip.</p> <p>A. The record included physician orders dated 11-27-13, 12-11-13, 12-18-13, and 1-9-14 that state, "wash, rinse, peri [with] hibiclens protecting open wound. Irrigate with 20 cc [cubic centimeters] NS [normal saline] piston syringe, Collagen powder to undermining, adaptic, ABD pad, . . . tape."</p> <p>B. Skilled nurse visit notes, dated 11-29-13, 12-2-13, 12-6-13, 12-9-13, 12-13-13, 12-17-13, 12-20-13, 12-23-13, 12-27-13, 12-30-13, 1-3-14, 1-6-14, 1-10-14, 1-13-14, 1-17-14, and 1-20-14, evidenced the dressing change</p>	G000165	G165Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.24 Plan of Care and Physician Orders. Education included information that all care and services including drugs and treatments are provided according to current physician orders. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient# 4 - A wound order clarification was obtained from the physician on 1-28-14 and reviewed with staff. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Physician notified on 12-9-13 of the change in the plan of care for week of 12-7-13, notified on 12-22-13 for week of 12-23-13 and notified 12-29-13 for week of 12-27-13. Clarification on 2-17-14 - change in plan of care at patient request. Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Addendum note 2-17-14 to address dressing change. Patient # 16 - Discharged 9-23-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor that all care and services including drugs and	02/27/2014			

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	<p>had not been performed as ordered.</p> <p>The notes state, "Cleanse incision with hibiclens, apply collagen powder to wound, cover with adaptic pad and cover with ABD, secure with tape." The notes failed to evidence the peri area had been washed and rinsed, that the wound had been irrigated with normal saline using a piston syringe, and that hibiclens had been used to clean the wound.</p> <p>C. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 1:30 PM, the visit notes did not evidence the dressing change had been completed as ordered.</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment states, "PT/INR [blood test] per coagucheck done with results of 1.5 reported to [name of physician] office."</p> <p>A. The record failed to include an order for the blood test to be completed.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p>		<p>treatment are provided per physician orders for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>3. A home visit was made to patient number 8 on 1-23-14 at 3:30 PM with employee G, a registered nurse (RN). The RN was observed to apply a topical diabetic ulcer prevention cream to the patient's buttocks.</p> <p>A. Clinical record number 8 failed to include an order for the diabetic ulcer prevention cream.</p> <p>B. The record included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information regarding an order for the diabetic ulcer prevention cream and indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. Clinical record number 9 included plans of care, established by the physician for the certification periods 11-16-13 to 1-14-14 and 1-15-14 to 3-15-14, that identified home health aide services were to be provided 3 times per</p>						

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	<p>week. The record evidenced only 2 home aide visits had been provided the weeks of 12-7-13, 12-22-13, and 12-29-13.</p> <p>A. The plans of care identified skilled nurse services were to be provided every other week throughout the certification periods. The record evidenced skilled nurse services had been provided weekly the weeks of 11-30-13, 12-7-13, and 12-14-13. The record failed to evidence an order for the weekly skilled nurse visits.</p> <p>B. The record included a verbal order, signed and dated by the physical therapist, employee K, on 11-29-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform: 1 Time every other day . . . remove old dressing and discard per policy Cleanse with normal saline apply Normlgel to wound Cover with Alldress." The record failed to evidence the dressing change had been completed every other day as ordered."</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p>						

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	<p>5. Clinical record number 16 included an initial comprehensive assessment completed by a physical therapist, employee L, on 8-6-13. The assessment identified the patient had a surgical wound to the right knee with a small amount of serosanguinous drainage and that the tissue around the wound appeared "red/inflamed." The assessment evidenced the therapist had applied a "dry dressing, 4 X 4, coverall."</p> <p>A. The record failed to include an order for the dressing.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>6. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan . . . All care and services provided is according to current physician orders."</p>			

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G000168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure the registered nurse had provided treatments and services as ordered by the physician in 5 of 16 records reviewed creating the potential to affect all of the agency's 172 current patients (See G 170); by failing to ensure the registered nurse had initiated nursing procedures for the assessment and care of patients in 3 of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services (See G 175); and by failing to ensure coordination of services among agency staff and with other health care providers had occurred and the physician had been notified of changes in 4 of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency's being found out of compliance with this condition, 42 CFR 484.30 Skilled</p>	G000168	G168 See G170, G175 and G176	02/27/2014

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G000170	<p>Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the registered nurse had provided treatments and services as ordered by the physician in 5 (#s 4, 6, 8, 9, & 12) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure drugs and treatments had been provided as ordered by the physician in 5 (#s 4, 6, 8, 9, & 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 identified skilled nurse services had been provided 2 times per week during the certification periods 11-10-13 to 1-8-14 and 1-9-14</p>	G000170	<p>G170Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.24 Plan of Care and Physician Orders. Education included information that all care and services including drugs and treatments are provided according to current physician orders. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient# 4 - A wound order clarification was obtained from the physician on 1-28-14 and reviewed with staff. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Physician notified on 12-9-13 of the change in the plan of care for week of 12-7-13, notified on 12-22-13 for week of 12-23-13 and notified 12-29-13 for week of 12-27-13. Clarification on 2-17-14 - change in plan of care at patient request. Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Addendum note 2-17-14 to</p>	02/27/2014

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	<p>to 3-9-14 for dressing changes to a wound on the right hip.</p> <p>A. The record included physician orders dated 11-27-13, 12-11-13, 12-18-13, and 1-9-14 that state, "wash, rinse, peri [with] hibiclens protecting open wound. Irrigate with 20 cc [cubic centimeters] NS [normal saline] piston syringe, Collagen powder to undermining, adaptic, ABD pad, . . . tape."</p> <p>B. Skilled nurse visit notes, dated 11-29-13, 12-2-13, 12-6-13, 12-9-13, 12-13-13, 12-17-13, 12-20-13, 12-23-13, 12-27-13, 12-30-13, 1-3-14, 1-6-14, 1-10-14, 1-13-14, 1-17-14, and 1-20-14, evidenced the dressing change had not been performed as ordered.</p> <p>The notes state, "Cleanse incision with hibiclens, apply collagen powder to wound, cover with adaptic pad and cover with ABD, secure with tape." The notes failed to evidence the peri area had been washed and rinsed, that the wound had been irrigated with normal saline using a piston syringe, and that hibiclens had been used to clean the wound.</p> <p>C. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 1:30 PM, the visit notes did not</p>		<p>address dressing change. Patient # 12- Discharged 1-2-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor provision of care and services per physician orders for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>evidence the dressing change had been completed as ordered.</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment states, "PT/INR [blood test] per coagucheck done with results of 1.5 reported to [name of physician] office."</p> <p>A. The record failed to include an order for the blood test to be completed.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>3. A home visit was made to patient number 8 on 1-23-14 at 3:30 PM with employee G, a registered nurse (RN). The RN was observed to apply a topical diabetic ulcer prevention cream to the patient's buttocks.</p> <p>A. Clinical record number 8 failed to include an order for the diabetic ulcer prevention cream.</p> <p>B. The record included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week]</p>						

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	<p>12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information regarding an order for the diabetic ulcer prevention cream and indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. Clinical record number 9 included plans of care, established by the physician for the certification periods 11-16-13 to 1-14-14 and 1-15-14 to 3-15-14, that identified home health aide services were to be provided 3 times per week. The record evidenced only 2 home aide visits had been provided the weeks of 12-7-13, 12-22-13, and 12-29-13.</p> <p>A. The plans of care identified skilled nurse services were to be provided every other week throughout the certification periods. The record evidenced skilled nurse services had been provided weekly the weeks of 11-30-13, 12-7-13, and 12-14-13. The record failed to evidence an order for the weekly skilled nurse visits.</p>						

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	<p>B. The record included a verbal order, signed and dated by the physical therapist, employee K, on 11-29-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform: 1 Time every other day . . . remove old dressing and discard per policy Cleanse with normal saline apply Normlgel to wound Cover with Alldress." The record failed to evidence the dressing change had been completed every other day as ordered."</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 11-10-13 to 1-8-14 that states, "SN [skilled nurse] 1 w 9 [1 time per week for 9 weeks]."</p> <p>A. The record failed to evidence a SN visit had been provided the week of 11-10-13.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p>			

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G000175	<p>6. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan . . . All care and services provided is according to current physician orders."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse had initiated nursing procedures for the assessment and care of patients in 3 (#s 3, 6, and 7) of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services.</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 12-13-13 to 2-10-14. The plan of care states, "SN to</p>	G000175	G175Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.17 Medical Supervision and policy # 33.08 Nursing Service. Education was provided related to initiation of nursing interventions for assessment and care of the patient. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center and nursing interventions clarified	02/27/2014

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	<p>instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p> <p>A. The record failed to evidence the registered nurse had initiated appropriate nursing interventions to address the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant with the ordered diet and had blood glucose readings above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non compliance" with the prescribed diet and that the patient's blood sugar reading was 209. The note states, "Patient states had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p>		<p>on 1-23-14. Clarification with physician on 2-18-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor initiation of nursing interventions for 3 months starting week of 2-17-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p> <p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p> <p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt doesn't follow diet."</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment</p>				

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	<p>dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>A. The record failed to evidence the registered nurse had initiated and/or implemented any preventative nursing interventions related to the care of the patient's dialysis access site.</p> <p>B. During a home visit to patient number 6, on 1-23-14 at 10:30 AM, the patient stated, "I have had to tell them [agency staff] not to take a blood pressure in my left arm."</p> <p>3. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified</p>				

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G000176	<p>with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had initiated and/or implemented any preventative nursing interventions related the care of the patient's central venous catheter or the maturing fistula.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE 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. Based on clinical record review and interview, the registered nurse failed to ensure coordination of services among agency staff and with other health care providers had occurred and the physician had been notified of changes in 4 (#s 3, 6, 7, and 8) of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services.</p>	G000176	G176Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding coordination of services among agency staff and with other healthcare providers was	02/27/2014	

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	<p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-13-13 to 2-10-14. The plan of care states, "SN to instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p> <p>A. The record failed to evidence the nurse had notified the physician of the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant with the ordered diet and had blood glucose reading above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non</p>		<p>included. Education was provided regarding policy # 33.24 Plan of Care and Physician Orders. Education included information that agency staff are to notify the physician with any change in condition. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Clarification with physician on 2-18-14. No additional orders received. Patient # 8 - Discharged on 1-28-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor coordination of care and physician notification of change in condition for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>compliance" with the prescribed diet and that the patient's blood sugar reading was 209. The note states, "Patient states had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p> <p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p> <p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p> <p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt [patient] doesn't follow diet."</p>			

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	<p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>3. During a home visit to patient number 7, on 1-23-14 at 1:05 PM, with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose</p>			

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G000184	<p>of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>4. Clinical record number 8 included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>A. The record failed to evidence the registered nurse had coordinated with the occupational therapist to ensure the OT evaluation had been completed.</p> <p>B. The Manager of Clinical Services, employee B, indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>5. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>484.32 THERAPY SERVICES Based on clinical record and agency</p>	G000184	G184See G188 and G190	02/27/2014			

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G000188	<p>policy review, interview, and review of the Indiana Practice Act, it was determined the agency failed to maintain compliance with this condition by failing to ensure the qualified physical therapist consulted with the physician regarding the discontinuation of therapy services in 1 of 11 records reviewed of patients that received physical therapy (PT) services creating the potential to affect all of the agency's 88 current patients that receive PT services (See G 188) and by failing to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 5 of 11 records reviewed of patients that received services from the PTA creating the potential to affect all of the agency's 88 current patients that receive physical therapy services (See G 190).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.32 Therapy Services.</p> <p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on clinical record and agency</p>	G000188	G188Mandatory inservices were	02/27/2014

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	<p>policy review and interview, the agency failed to ensure the qualified physical therapist consulted with the physician regarding the discontinuation of therapy services in 1 (#11) of 11 records reviewed of patients that received physical therapy (PT) services creating the potential to affect all of the agency's 88 current patients that receive PT services.</p> <p>The findings include:</p> <p>1. Clinical record number 11 included a verbal order dated 1-12-14 that evidenced PT services were to be provided 2 times per week for 3 weeks for therapeutic exercises, establishment of a home exercise program, and gait/balance training activities.</p> <p>A. The record included a PT visit note, signed and dated by the physical therapy assistant, employee M, on 1-21-14. The visit note states, "D/C [discontinue] home care physical therapy with OT [occupational therapy] and nurse to continue treatment."</p> <p>B. The record failed to evidence the qualified physical therapist had consulted with the physician regarding the discontinuation of the PT services.</p>		<p>held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Therapy staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.09 Physical Therapy Services and included education regarding physician consultation by the qualified physical therapist regarding discontinuation of services. Educational packets mailed to all Professional Therapy staff that were unable to attend the in-service on 2-17-14. Patient # 11- Discharged 1-27-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per month to monitor therapy services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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G000190	<p>2. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-29-14 at 10:00 AM and 12:40 PM.</p> <p>3. The agency's 4-4-13 "Physical Therapy Services" policy number 33.09 states, "The duties of the therapist include the following . . . Communicates with the physician regarding the evaluation of patient functional levels Advises and consults with patients and patient families and other home health care staff members."</p> <p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist. Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 5 (#s 3, 5, 7, 13,</p>	G000190	G190Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Therapy Staff by the Director of Clinical Services (DCS) and Educator regarding policy# 33.10 Physical Therapy Assistant Services and policy# 33.09 Physical Therapy Services. Education was provided	02/27/2014

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	<p>and 15) of 11 records reviewed of patients that received services from the PTA creating the potential to affect all of the agency's 88 current patients that receive physical therapy services.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments."</p> <p>2. The agency's 4-4-13 "Physical Therapy Services" policy number 33.09 states, "All physical therapy services offered directly or under contractual arrangements are provided by or under the supervision of a qualified physical therapist, in accordance with physician plan of treatment . . . The duties of the therapist include the following: . . .</p>		<p>regarding services furnished by a qualified physical therapy assistant and the required supervision and documentation of supervision by a qualified physical therapist. Educational packets mailed to all Professional Therapy staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 5 - Discharged on 2-6-14. Patient # 7 - Process instituted 2-11-14 for documentation of daily supervision of PTA by qualified Physical Therapist. Patient # 13 - Discharged 1-29-14. Patient # 15 - 10-28-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per month to monitor therapy services and supervision of PTA by qualified physical therapist for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>Supervises and evaluated care rendered by Physical Therapy Assistant. Cosigns all clinical documentation as required."</p> <p>3. Clinical record number 3 evidenced physical therapy services had been ordered by the physician 2 times per week during the certification period 12-13-13 to 2-10-14 and that the physical therapy services had been discontinued on 1-3-14. The record evidenced the PTA, employee N, had provided services to the patient on 12-19-13, 12-20-13, 12-24-13, 12-27-13, and 12-30-13.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist to review this patient's treatment at least once each working day. The PTA visit notes, dated 12-19-13, 12-20-13, 12-24-13, 12-27-13, and 12-30-13, evidenced the supervising physical therapist, employee K, had reviewed and signed the notes on 1-16-14, 13 days after the physical therapy had been discontinued.</p> <p>4. Clinical record number 5 evidenced physical therapy services had been ordered by the physician 4 times per week for 1 week, 5 times per week for 1 week, and 3 times per week for 2 weeks during the certification period 1-13-14 to</p>						

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	<p>3-13-14. The record evidenced the PTA, employee M, had provided services to the patient on 1-15-14 and 1-17-14 and that another PTA, employee N, had provided services on 1-20-14, 1-21-14, and 1-23-14.</p> <p>A. The record failed to evidence the PTAs had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes, dated 1-15-14 and 1-17-14, evidenced the supervising physical therapist, employee O, had reviewed and signed the note on 1-20-14, 3 and 5 days after the care had been provided.</p> <p>B. The 1-20-14, 1-21-14, and 1-23-14 PTA visit notes failed to evidence any supervising physical therapist had reviewed the care provided to the patient and had co-signed the visit note.</p> <p>5. Clinical record number 7 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 3 weeks during the certification period 12-25-13 to 2-22-14. The record evidenced the PTA, employee M, had provided services to the patient on 12-27-13, 12-31-13, 1-7-14, 1-9-14, and</p>						

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	<p>1-14-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes evidenced the supervising physical therapist, employee K, had reviewed and signed the notes on 1-16-14, 2 to 14 days after the services had been provided.</p> <p>6. Clinical record number 13 evidenced physical therapy services had been ordered by the physician 1 time per week for an evaluation and then 1 time per week for 1 week and 2 times per week for 2 weeks during the certification period 1-14-14 to 3-14-14. The record evidenced the PTA, employee M, had provided services to the patient on 1-23-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit note evidenced the supervising physical therapist, employee O, had reviewed and co-signed the note on 1-27-14, 4 days after the service had been provided.</p>			

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	<p>7. Clinical record number 15 evidenced physical therapy services had been ordered by the physician 2 times per week for 3 weeks, 1 time per week for 1 week, then 2 times per week for 3 weeks and 1 time per week for 1 week, then 1 time per week for 1 week and 2 times per week for 3 weeks. The record evidenced the PTA, employee I, provided services to the patient on 8-14-13, 8-19-13, 8-26-13, 9-11-13, 9-16-13, and 9-18-13.</p> <p>A. The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes dated 8-14-13 and 8-19-13 evidenced the supervising physical therapist, employee O, had reviewed and co-signed the visit notes on 8-22-13, 3 to 8 days after the services had been provided.</p> <p>B. The 8-26-13 PTA visit note evidenced the supervising physical therapist, employee O, had reviewed the care and co-signed the note on 8-29-13, 3 days after the care had been provided.</p> <p>C. The 9-11-13, 9-16-13, and 9-18-13 PTA visit notes evidenced the supervising physical therapist, employee O, had reviewed the care and co-signed</p>			

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G000229	<p>the visit notes on 10-1-13, 12 to 19 days after the care had been provided.</p> <p>8. The Administrator, employee A, indicated, on 1-29-14 at 10 AM, the physical therapists and the physical therapy assistants meet every morning at the agency. The Administrator indicated the PTA visit notes did not evidence the supervising physical therapists had reviewed each patient's treatment.</p> <p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed an on-site visit to the patient's home at least every 2 weeks in 1 (# 14) of 6 records reviewed of patients that received both skilled services and home health aide services from the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 14 evidenced skilled nursing services had been provided 1 time per month for 2 months and home health aide services had been</p>	G000229	G229Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional/Para Professional and Scheduling Staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.16 Supervision of Para Professionals. Education included information that on site supervisory visits are completed at least every two weeks. Educational packets mailed to all Professional/Para Professional /Scheduling staff that were unable to attend the in-service on 2-17-14. Patient # 14 - Physician notified 1-29-14 of the change in the plan of care. To ensure	02/27/2014

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	<p>provided 3 times per week during the certification period 12-1-13 to 1-29-14. The record failed to evidence the RN had completed an on-site supervisory visit at least every 2 weeks during the month of December 2013.</p> <p>A. The record evidenced the SN had completed a supervisory visit on 12-10-13 and not again until 1-8-14.</p> <p>B. The Manager of Clinical Services, employee B, indicated, on 1-29-14 at 12:40 PM, the RN had not completed a supervisory visit at least every 2 weeks. The Manager stated, "The RN attempted a visit on 12-24 but the patient was not at home. I don't know if she attempted any other time during the week to make the visit."</p> <p>2. The agency's 7-10-13 "Supervision of Paraprofessionals" policy number 33.16 states, "State licensure and regulations - Aide with a skill. Once a month but to comply with Medicare they must be done q [every] 2 weeks. Aide may or may not be present."</p>		<p>compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per month to monitor supervisory visits for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure comprehensive assessments were complete and accurately reflected the patients' status in 1 of 16 records reviewed creating the potential to affect all of the agency's 172 current patients (See G 335); by failing to ensure comprehensive assessments included a review of all medications in 2 of 16 records reviewed creating the</p>	G000330	G330See G335, G337, G338, G339 and G341	02/27/2014

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	<p>potential to affect all of the agency's 172 current patients (See G 337); by failing to have a policy in place that specifies the agency's definition of a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment creating the potential to affect all of the agency's 172 current patients (See G 338); failing to ensure recertification comprehensive assessments were complete and accurately reflected the patients' status in 3 of 8 records reviewed of patients receiving services more than 60 days creating the potential to affect all of the agency's current patients that receive services longer than 60 days (See G 339); and by failing to ensure the comprehensive assessment had been updated within 48 hours of discharge in 1 of 2 discharged records reviewed and upon transfer to an inpatient facility in 1 of 2 records reviewed of patients transferred to an inpatient facility creating the potential to affect all of the agency's 172 current patients (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.</p>			

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G000335	<p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure the start of care comprehensive assessment were complete and accurately reflected the patients' status in 1 (#s 6) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p>	G000335	<p>G335Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.106 Comprehensive Assessment & OASIS Management and policy 33.43 Assessment of Patient. Education included ensuring the start of care comprehensive assessment is complete and accurately reflects the patient status. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor the comprehensive assessment for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This</p>	02/27/2014
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G000337	<p>A. The assessment failed to to include an assessment of the patient's condition related to the dialysis.</p> <p>B. During a home visit to patient number 6, on 1-23-14 at 10:30 AM, the patient stated, "I have had to tell them [agency staff] not to take a blood pressure in my left arm."</p> <p>2. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and on 1-29-14 at 10 AM.</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record review and interview, the agency failed to ensure comprehensive assessments included a review of all medications in 2 (#s 6 & 7) of 16 records reviewed creating the potential to affect all of the agency's 172</p>			G000337	<p>compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G337 Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.04 Medication Management and policy # 33.48</p>		02/27/2014

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	<p>current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment failed to include a review of medications administered to the patient during dialysis treatments and all home medications the patient was known to be taking.</p> <p>A. The administrator, employee A, obtained dialysis orders, including a list of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders identified Epogen 2200 units and Liquacel 1 ounce was administered to the patient during each dialysis treatment 3 times per week. The comprehensive assessment failed to include a review of these dialysis medications</p> <p>B. The dialysis orders identified home medications Nitrostat 0.4 milligrams as needed for chest pain, Dialyvite one tablet daily, Synthroid 112 micrograms, and Milk of Magnesia 30 milliliters daily as needed for constipation had been ordered. The comprehensive assessment failed to</p>		<p>Comprehensive Drug Regimen Review, Adverse Drug Reactions, and Medication Errors Response. Education was provided regarding review of all medications with the comprehensive assessment. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Physician clarification and medication reconciliation and medication profile updated 2-18-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor review of medication for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>include a review of these home medications.</p> <p>2. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13. The assessment failed to include a review of medications administered to the patient during dialysis treatments and all home medications the patient was known to be taking.</p> <p>B. The administrator, employee A, obtained dialysis orders, including a list of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders indicated Epogen 2200 units was administered to the patient 3 times per week during the dialysis treatment and that Venofer 50 milligrams was administered 1 time per week. The comprehensive assessment failed to include a review of these dialysis medications.</p>						

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G000338	<p>C. The dialysis orders evidenced Labetalol 20 milligrams had been ordered intravenously as needed for blood pressure problems, Lidocaine 1% topically to needle insertion sites, and nitoglycerin 0.4 milligrams as needed for chest pain had been ordered as needed. The assessment failed to include a review of these home medications.</p> <p>3. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and on 1-29-14 at 10 AM.</p> <p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. Based on policy and procedure review and interview, the agency failed to have a policy in place that specifies the agency's definition of a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment creating the potential to affect all of the agency's 172 current patients.</p>	G000338	G338Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.106 Comprehensive & OASIS Management. This policy was revised to include definition of major decline or improvement in a patients condition that would warrant an update of the	02/27/2014

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G000339	<p>The findings include:</p> <p>1. The agency's policy and procedure manuals failed to include a policy that defines a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment.</p> <p>2. The Administrator, employee A, stated, on 1-29-14 at 2 PM, "I found a SCIC policy in the archived policies and procedures. It is no longer in effect." The administrator indicated the agency does not currently have a policy that specifies the agency's definition of a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment.</p> <p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review and interview, the agency failed to ensure recertification comprehensive</p>			G000339	<p>comprehensive assessment. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor for a decline or improvement in patient condition for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G339Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director</p>		02/27/2014

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	<p>assessments were complete and accurately reflected the patients' status in 3 (#s 7, 8, and 9) of 8 records reviewed of patients receiving services more than 60 days creating the potential to affect all of the agency's current patients that receive services longer than 60 days.</p> <p>The findings include:</p> <p>1. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The assessment failed to include an assessment of the patient's condition related to the dialysis.</p> <p>2. Clinical record number 8 included a</p>		<p>of Clinical Services (DCS) and Educator regarding Policy # 33.106 Comprehensive Assessment and OASIS Management and Policy # 33.43 Assessment of Patient. Education was provided to address recertification comprehensive assessments are complete and accurate and reflect the patients status. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Clarification with physician on 2-18-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Clarification and physician notification 2-18-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor for accuracy and completion of comprehensive assessment for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>recertification comprehensive assessment dated 1-16-14. On page 11 of the assessment, it states, "No pressure ulcers." Pages 16 through 21 of the assessment describe, and have pictures of, 5 different pressure ulcers on the patient's buttocks. The assessment failed to accurately reflect the patient's current health status.</p> <p>3. Clinical record number 9 included a recertification comprehensive assessment dated 1-14-14. The assessment identifies the patient has a "chronic kidney disease, Stage V" and has a "non function AV fistula It arm . . . dialysis."</p> <p>A. The Manager of Clinical Services, employee B, stated, on 1-27-14 at 3:15 PM, "The patient does have a non functioning fistula. The patient has refused dialysis."</p> <p>B. The comprehensive assessment failed to evidence an assessment of the patient's condition related to the patient's refusal of dialysis treatments.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and on 1-29-14 at 10 AM.</p>			

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated within 48 hours of discharge in 1 (# 12) of 2 discharged records reviewed and upon transfer to an inpatient facility in 1 (# 15) of 2 records reviewed of patients transferred to an inpatient facility creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 11:30 AM, the agency became aware of the patient number 12's desire to be discharged from services on 1-7-14. The Manager stated "The patient [patient number 12] called us on 1-7-14 and indicated [the patient] wanted to cancel the home care services."</p> <p>A. Clinical record number 12 evidenced the discharge comprehensive</p>	G000341	<p>G341Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.106 Comprehensive Assessment and OASIS Management. Education included information that the comprehensive assessment must be updated and revised at discharge and transfer within 48 hours. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 12- Discharged 1-2-14. Patient # 15 - Discharged 10-28-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 4 chart reviews per month to monitor appropriate completion of the comprehensive assessments at discharge and transfer for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of</p>	02/27/2014
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	<p>assessment had been completed on 1-10-14, 72 hours after knowledge of the patient's desire to be discharged from the agency.</p> <p>B. The agency's 8-30-12 "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "Discharge Comprehensive Assessment including OASIS: Complete within 48 hours (or knowledge of) any time a patient is discharged from all skilled services."</p> <p>2. Clinical record number 15 included a hospital history and physical that evidenced the patient had been admitted to the hospital on 9-19-13. The record failed to evidence the transfer assessment had been completed upon the patient's transfer to the hospital.</p> <p>A. The record included a resume home care verbal order dated 9-23-13.</p> <p>B. The record included a resumption of care comprehensive assessment dated 9-23-13.</p> <p>C. The agency's 8-30-12 "Comprehensive Assessment and OASIS Management" policy number 33.106 states, "Transfer Comprehensive Assessment including OASIS completed</p>		Operations with oversight by the Regional Clinical Manager and Regional Vice President.		

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N000000	<p>anytime a patient is admitted to an inpatient facility for more than 24 hours."</p> <p>3. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-29-14 at 10 AM.</p> <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 1-22-14, 1-23-14, 1-24-14, 1-27-14, 1-28-14, & 1-29-14.</p> <p>Facility # 005945</p> <p>Medicaid Vendor: 200500550A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census:</p> <p>155 skilled 17 home health aide only 0 personal services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	N000000		

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N000470	<p>February 3, 2014</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of agency policy, the agency failed to ensure staff had provided services in accordance with its own infection control policies and procedures and topical medication application policies and procedures in 5 (#s 2, 4, 5, 6, & 7) of 8 home visit observations completed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's 3-26-12 "Standard (Universal) Precautions" policy number 33.39 states, "Standards precautions will be followed on all patients." 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 	N000470	<p>N470Mandatory inservices for all Professional/Paraprofessional staff were held on 2-11-14, 2-13-14, 2-14-14 and 2-17-14 by the Director of Clinical Services (DCS) and Educator regarding policy # 33.83 Bag Technique, policy #33.39 Standard (Universal) Precautions, policy #33.900 Hand Hygiene and policy # 33.130 Clinical Equipment Management. Return demonstration of appropriate hand hygiene technique and bag technique demonstration was included. Education for Professional staff regarding policy # 33.713 Topical Ointment/Cream Application and the appropriate application of topical creams and ointments according to the agency policy was also provided. Education packets mailed on 2-17-14 to all Professional/Paraprofessional staff that were unable to attend the inservice. Return demonstration of hand hygiene and bag technique is being individually scheduled with staff unable to attend. To ensure</p>	02/27/2014			

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	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, nonintact skin, or wound dressings. 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). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . 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 . . . IV.B. Personal protective equipment (PPE) . . . 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."		compliance with the above policies and procedures the DCS or designee will conduct 6 home visits per month for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly quality monitoring. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	

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	<p>3. The agency's 6-15-09 "Topical Ointment/Cream Application" policy number 33.713 states, "Apply topical ointment/cream to client's body part, wearing plastic gloves and using a tongue depressor or a swab."</p> <p>4. Home visit # 2 was completed on 1-23-14 at 1:05 PM to patient number 7 with the registered nurse (RN), employee H. The RN was observed to perform a dressing change to the patient's right hip.</p> <p>A. The RN donned clean gloves and removed the patient's shoes and touched the patient's feet. She charted her findings by touching the keyboard of her computer with gloved hands. The RN failed to remove her gloves and cleanse her hands prior to touching the computer.</p> <p>B. With the same gloves on, the RN then gathered clean supplies to perform the dressing change. She removed her gloves and washed her hands. She donned clean gloves and gathered more supplies from the patient's home supply. She prepared the supplies on a pad on the bed next to the patient. She cut the Coverall to size in preparation for the dressing change. Without changing her</p>						

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	<p>gloves or cleansing her hands, the RN then removed the old dressing. The RN then removed her gloves and cleansed her hands.</p> <p>C. Observation noted the RN's hair hanging down over her gloved hand and touching the gloved hand while the RN completed the dressing change.</p> <p>D. The RN was observed to apply a topical ointment to a reddened area on the patient's sacrum using her gloved finger instead of a tongue depressor or swab.</p> <p>5. Home visit # 4 was completed on 1-23-14 at 3:30 PM to patient number 8 with the RN, employee G. The RN was observed to perform an assessment of the patient.</p> <p>A. The RN was observed to use her stethoscope to listen to the patient's heart, lungs, and abdomen. The RN was observed to place the stethoscope around her neck without cleansing it creating the potential of the transfer of any disease causing pathogens from the patient's body to the nurse's clothing.</p> <p>B. The RN was observed to apply a diabetic ulcer prevention cream to the patient's buttocks using a her gloved</p>			

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	<p>finger instead of a tongue depressor or a swab.</p> <p>6. Home visit # 5 was completed on 1-24-14 at 10 AM to patient number 9 with the home health aide, employee C. The aide was observed to perform a glove change without cleansing her hands after touching the patient.</p> <p>7. Home visit # 6 was completed on 1-24-14 at 11:05 AM to patient number 10 with the home health aide, employee E. The aide was observed to shave the patient without wearing gloves creating the potential for exposure to the patient's blood.</p> <p>A. After washing, rinsing, and drying the patient's buttocks and perineal area with gloves hands, the aide then applied lotion to the patient's knees and upper legs without changing her gloves or cleansing her hands.</p> <p>B. After applying the lotion, the aide then changed her gloves but failed to cleanse her hands. The aide assisted the patient to pull up the adult diaper. The aide removed her gloves and failed to cleanse her hands and assisted the patient to apply a shirt and pull up the pants.</p>						

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	<p>8. Home visit number 7 was completed on 1-24-14 at 12:45 PM to patient number 4 with the RN, employee P. The RN was observed to remove a thermometer covered with a plastic sheath from the patient's mouth without wearing gloves creating the potential for transfer of disease causing organisms from the patient's saliva to the nurse's hand.</p> <p>After removing the thermometer from the patient's mouth, the RN then cleaned her blood pressure cuff and stethoscope with a bleach disposal wipe. The RN then used this same wipe to cleanse her hands and touched her computer keyboard.</p> <p>9. The above-stated findings were discussed with the Manager of Clinical Services, employee B, and the Administrator, employee A, on 1-29-14 at 10 AM. The Manager and the Administrator agreed agency staff had not provided services in accordance with agency policy.</p>				

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review and interview, the registered nurse failed to ensure coordination of services among agency staff and with other health care providers had occurred in 1 (#s 8) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 8 included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed. <p>A. The record failed to evidence the registered nurse had coordinated with the occupational therapist to ensure the OT evaluation had been completed.</p> <p>B. The Manager of Clinical Services, employee B, indicated the OT evaluation</p>	N000484	<p>M484Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding coordination of services among agency staff and with other healthcare providers was included. Education was provided regarding policy # 33.24 Plan of Care and Physician Orders. The inservice included appropriate documentation and physician notification if service is refused. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 8 - Discharged on 1-28-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor coordination of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the</p>	02/27/2014

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N000486	<p>had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>2. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on clinical record review and interview, the registered nurse failed to ensure coordination of services with other health care providers had occurred in 2 (#s 6 and 7) of 2 records reviewed of patients that received services from other health care providers creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a</p>	N000486	<p>agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>N486Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding coordination of services among agency staff and with other healthcare providers was included. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center</p>	02/27/2014	

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	<p>start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>2. During a home visit to patient number 7, on 1-23-14 at 1:05 PM, with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p>		<p>on 1-23-14. Clarification with physician on 2-18-14. No additional orders received. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor coordination of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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N000522	<p>3. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure visits and treatments had been provided as ordered by the physician in 7 (#s 4, 5, 6, 8, 9, 12, & 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 identified skilled nurse services had been provided 2 times per week during the certification periods 11-10-13 to 1-8-14 and 1-9-14 to 3-9-14 for dressing changes to a wound on the right hip.</p>	N000522	N522Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders. The inservice included information that the medical care shall follow a written medical plan of care established and periodically reviewed by the physician. All visits and treatments, care and services are provided according to current physician orders. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient# 4 - A wound order clarification was obtained from the physician on 1-28-14 and	02/27/2014

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	<p>A. The record included physician orders dated 11-27-13, 12-11-13, 12-18-13, and 1-9-14 that state, "wash, rinse, peri [with] hibiclens protecting open wound. Irrigate with 20 cc [cubic centimeters] NS [normal saline] piston syringe, Collagen powder to undermining, adaptic, ABD pad, . . . tape."</p> <p>B. Skilled nurse visit notes, dated 11-29-13, 12-2-13, 12-6-13, 12-9-13, 12-13-13, 12-17-13, 12-20-13, 12-23-13, 12-27-13, 12-30-13, 1-3-14, 1-6-14, 1-10-14, 1-13-14, 1-17-14, and 1-20-14, evidenced the dressing change had not been performed as ordered.</p> <p>The notes state, "Cleanse incision with hibiclens, apply collagen powder to wound, cover with adaptic pad and cover with ABD, secure with tape." The notes failed to evidence the peri area had been washed and rinsed, that the wound had been irrigated with normal saline using a piston syringe, and that hibiclens had been used to clean the wound.</p> <p>C. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 1:30 PM, the visit notes did not evidence the dressing change had been completed as ordered.</p>		<p>reviewed with staff. Patient # 5 - Discharged on 2-6-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Physician notified on 12-9-13 of the change in the plan of care for week of 12-7-13, notified on 12-22-13 for week of 12-23-13 and notified 12-29-13 for week of 12-27-13.</p> <p>Clarification on 2-17-14 - change in plan of care at patient request. Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Addendum note 2-17-14 to address dressing change. Patient # 12- Discharged 1-2-14. Patient # 16 - Discharged 9-23-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor physician orders for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 1-13-14 to 3-13-14 that identified physical therapy (PT) services were to be provided 4 times per week for 1 week, 5 times per week for 1 week, and 3 times per week for 2 weeks. The plan states, "PT Agency clinicians to address the following . . . DIABETIC FOOT CARE: Assess feet and lower extremities for open areas, injury, or new/increased sensations of numbness/tingling. Instruct on proper diabetic foot care . . . DEPRESSION: Monitor for S/S [signs and symptoms] depression, monitor effectiveness of depression medication, refer to physician if client is experiencing signs of depression."</p> <p>A. PT visit notes, dated 1-14-14, 1-15-14, 1-17-14, 1-20-14, 1-21-14, and 1-23-14, failed to evidence the patient's feet and lower extremities had been assessed or that an assessment had been completed to monitor for any signs and symptoms of depression.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p>						

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	<p>3. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment states, "PT/INR [blood test] per coagucheck done with results of 1.5 reported to [name of physician] office."</p> <p>A. The record failed to include an order for the blood test to be completed.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>4. A home visit was made to patient number 8 on 1-23-14 at 3:30 PM with employee G, a registered nurse (RN). The RN was observed to apply a topical diabetic ulcer prevention cream to the patient's buttocks.</p> <p>A. Clinical record number 8 failed to include an order for the diabetic ulcer prevention cream.</p> <p>B. The record included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p>			

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	<p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information regarding an order for the diabetic ulcer prevention cream and indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>5. Clinical record number 9 included plans of care, established by the physician for the certification periods 11-16-13 to 1-14-14 and 1-15-14 to 3-15-14, that identified home health aide services were to be provided 3 times per week. The record evidenced only 2 home aide visits had been provided the weeks of 12-7-13, 12-22-13, and 12-29-13.</p> <p>A. The plans of care identified skilled nurse services were to be provided every other week throughout the certification periods. The record evidenced skilled nurse services had been provided weekly the weeks of 11-30-13, 12-7-13, and 12-14-13. The record failed to evidence an order for the weekly skilled nurse visits.</p> <p>B. The record included a verbal order, signed and dated by the physical therapist, employee K, on 11-29-13, that</p>						

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	<p>states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform: 1 Time every other day . . . remove old dressing and discard per policy Cleanse with normal saline apply Normlgel to wound Cover with Alldress." The record failed to evidence the dressing change had been completed every other day as ordered."</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 11-10-13 to 1-8-14 that states, "SN [skilled nurse] 1 w 9 [1 time per week for 9 weeks]."</p> <p>A. The record failed to evidence a SN visit had been provided the week of 11-10-13.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>7. Clinical record number 16 included an initial comprehensive assessment</p>			

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	<p>completed by a physical therapist, employee L, on 8-6-13. The assessment identified the patient had a surgical wound to the right knee with a small amount of serosanguinous drainage and that the tissue around the wound appeared "red/inflamed." The assessment evidenced the therapist had applied a "dry dressing, 4 X 4, coverall."</p> <p>A. The record failed to include an order for the dressing.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>8. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan . . . All care and services provided is according to current physician orders."</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> <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 and agency policy review and interview, the agency failed to ensure plans of care included frequency and duration of visits, who was to perform the treatment, and all medications in 5 (#s 2, 6, 7, 9, & 15) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p>	N000524	N524Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders. Education included information that the Plan of Care is to include frequency and duration of visits, who was to perform the treatment, and all medications. Educational packets mailed to all Professional staff that were unable to attend the	02/27/2014
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	<p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 1-3-14 to 3-3-14. The plan of care identified skilled nursing (SN) services were to be provided. The plan of care states, "SN Agency clinicians to address the following during the episode . . . [vital sign parameters to be reported to the physician] . . . pulse ox prn [oximetry when needed] . . . fall prevention . . . pain."</p> <p>The plan of care failed to include the frequency and duration of the SN visits.</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The plan of care established by the physician for the certification period 1-9-14 to 3-9-14 failed to include current medications administered to the patient during the dialysis treatment.</p> <p>A. The administrator, employee A, obtained dialysis orders, including a list of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders identified Epogen 2200 units and Liquacel 1 ounce was administered to the patient during each dialysis</p>		<p>in-service on 2-17-14. Patient # 2 – Physician clarification order was obtained 2-17-14 for frequency and duration of SN visit. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Physician clarification and medication reconciliation and medication profile updated 2-18-14. Patient # 9 – Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Patient # 15 - Discharged 10-28-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random chart reviews per month to monitor plan of care and ordered services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>treatment 3 times per week. The plan of care states that the patient received Epogen 2000 units 2 times per week and failed to include the Liquacel.</p> <p>B. The dialysis orders identified home medications Nitrostat 0.4 milligrams as needed for chest pain, Dialyvite one tablet daily, Synthroid 112 micrograms, and Milk of Magnesia 30 milliliters daily as needed for constipation had been ordered. The plan of care failed to include the Nitrostat, the Dialyvite and the Milk of Magnesia. The plan of care evidenced Synthroid 100 micrograms daily.</p> <p>3. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays.</p> <p>A. The plan of care, established by the physician for the certification period 12-25-13 to 2-24-14, failed to include medications administered to the patient during the dialysis treatment and failed to include all home medications.</p> <p>B. The administrator, employee A, obtained dialysis orders, including a list</p>			

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	<p>of medications administered during the dialysis treatment, from the dialysis facility on 1-27-14. The dialysis orders indicated Epogen 2200 units was administered to the patient 3 times per week during the dialysis treatment and that Venofer 50 milligrams was administered 1 time per week. The plan of care failed to include the Epogen and Venofer.</p> <p>C. The dialysis orders evidenced Labetalol 20 milligrams had been ordered intravenously as needed for blood pressure problems, Lidocaine 1% topically to needle insertion sites, and nitoglycerin 0.4 milligrams as needed for chest pain had been ordered as needed. The plan of care failed to include these medications.</p> <p>4. Clinical record number 9 included an update to the plan of care, a verbal order dated 12-3-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform 1 Time Every Other Day. Remove old dressing and discard per policy. Cleanse with normal saline. Apply Normlgel to wound. Cover with Alldress."</p> <p>The order failed to evidence who was to perform the dressing change and how</p>			

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	<p>often visits were to be made to complete the dressing change.</p> <p>5. Clinical record number 15 included an update to the plan of care, a verbal order dated 9-5-13, that states, "SN Wound: anterior - right lateral calf skin tear . . . Perform: 1 time per day."</p> <p>The record failed to evidence who was to perform the dressing change and how often visits were to be made to complete the dressing change.</p> <p>6. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and on 1-29-14 at 12:40 PM.</p> <p>7. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The plan of care should be based upon a current assessment of the client's needs for care. The plan of care must include . . . types of services . . . frequency and duration of visits . . . all medications, all treatments."</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. Based on clinical record and agency policy review and interview, the agency failed to ensure agency staff had alerted the physician to changes in the patients' conditions in 2 (#s 3 and 16) of 16 records reviewed creating the potential to affect all of the agency's 172 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 12-13-13 to 2-10-14. The plan of care states, "SN to instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p>	N000527	<p>N527Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders and policy # 33.17 Medical Supervision. Education included information that agency staff are to notify the physician with any change in condition. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 16 – Discharged 9-23-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor physician notification of a change in condition for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	02/27/2014

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME CARE SERVICES OF VINCENNES IN				STREET ADDRESS, CITY, STATE, ZIP CODE 413 N FIRST ST VINCENNES, IN 47591			
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	<p>A. The record failed to evidence the nurse had notified the physician of the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant with the ordered diet and had blood glucose reading above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non compliance" with the prescribed diet and that the patient's blood sugar reading was 209. The note states, "Patient states had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p> <p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p>						

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	<p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p> <p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt doesn't follow diet."</p> <p>2. Clinical record number 16 included an initial comprehensive assessment completed by the physical therapist, employee L, on 8-6-13. The assessment identifies the patient has a surgical wound to the right knee with a small amount of serosanguinous drainage and that the tissue around the wound appears "red/inflamed." The assessment evidenced the therapist had applied a "dry dressing, 4 X 4, coverall."</p> <p>The record failed to evidence the physical therapist had notified the physician about the pressure area and had obtained ordered for the dressing change.</p>						

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N000537	<p>3. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>4. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care." 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, observation, and interview, the agency failed to ensure the registered nurse had provided treatments and services as ordered by the physician in 5 (#s 4, 6, 8, 9, & 12) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure drugs and treatments had been provided</p>	N000537	N537Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.08 Nursing Service and policy # 33.24 Plan of Care and Physician Orders. Education included information related to the provision of nursing services in accordance with the medical plan of care. All care and services including provision of drugs and treatments are provided is according to current physician orders. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient# 4	02/27/2014

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	<p>as ordered by the physician in 5 (#s 4, 6, 8, 9, & 16) of 16 records reviewed creating the potential to affect all of the agency's 172 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 identified skilled nurse services had been provided 2 times per week during the certification periods 11-10-13 to 1-8-14 and 1-9-14 to 3-9-14 for dressing changes to a wound on the right hip.</p> <p>A. The record included physician orders dated 11-27-13, 12-11-13, 12-18-13, and 1-9-14 that state, "wash, rinse, peri [with] hibiclens protecting open wound. Irrigate with 20 cc [cubic centimeters] NS [normal saline] piston syringe, Collagen powder to undermining, adaptic, ABD pad, . . . tape."</p> <p>B. Skilled nurse visit notes, dated 11-29-13, 12-2-13, 12-6-13, 12-9-13, 12-13-13, 12-17-13, 12-20-13, 12-23-13, 12-27-13, 12-30-13, 1-3-14, 1-6-14, 1-10-14, 1-13-14, 1-17-14, and 1-20-14, evidenced the dressing change had not been performed as ordered.</p> <p>The notes state, "Cleanse incision with hibiclens, apply collagen powder to</p>		<p>- A wound order clarification was obtained from the physician on 1-28-14 and reviewed with staff. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 8 - Discharged on 1-28-14. Patient # 9 - Physician notified on 12-9-13 of the change in the plan of care for week of 12-7-13, notified on 12-22-13 for week of 12-23-13 and notified 12-29-13 for week of 12-27-13. Clarification on 2-17-14 - change in plan of care at patient request. Physician clarification order obtained 2-17-14 for weekly skilled nursing visits. Addendum note 2-17-14 to address dressing change. Patient # 12- Discharged 1-2-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor provision of care and services per physician orders for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>wound, cover with adaptic pad and cover with ABD, secure with tape." The notes failed to evidence the peri area had been washed and rinsed, that the wound had been irrigated with normal saline using a piston syringe, and that hibiclens had been used to clean the wound.</p> <p>C. The Manager of Clinical Services, employee B, indicated, on 1-28-14 at 1:30 PM, the visit notes did not evidence the dressing change had been completed as ordered.</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14. The assessment states, "PT/INR [blood test] per coagucheck done with results of 1.5 reported to [name of physician] office."</p> <p>A. The record failed to include an order for the blood test to be completed.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>3. A home visit was made to patient number 8 on 1-23-14 at 3:30 PM with employee G, a registered nurse (RN). The RN was observed to apply a topical</p>			

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	<p>diabetic ulcer prevention cream to the patient's buttocks.</p> <p>A. Clinical record number 8 failed to include an order for the diabetic ulcer prevention cream.</p> <p>B. The record included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information regarding an order for the diabetic ulcer prevention cream and indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. Clinical record number 9 included plans of care, established by the physician for the certification periods 11-16-13 to 1-14-14 and 1-15-14 to 3-15-14, that identified home health aide services were to be provided 3 times per week. The record evidenced only 2 home aide visits had been provided the weeks of 12-7-13, 12-22-13, and 12-29-13.</p>			

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	<p>A. The plans of care identified skilled nurse services were to be provided every other week throughout the certification periods. The record evidenced skilled nurse services had been provided weekly the weeks of 11-30-13, 12-7-13, and 12-14-13. The record failed to evidence an order for the weekly skilled nurse visits.</p> <p>B. The record included a verbal order, signed and dated by the physical therapist, employee K, on 11-29-13, that states, "Beginning 12/03/13 Wound: Right side - Malleolus Pressure Ulcer - Stage III . . . Perform: 1 Time every other day . . . remove old dressing and discard per policy Cleanse with normal saline apply Normlgel to wound Cover with Alldress." The record failed to evidence the dressing change had been completed every other day as ordered."</p> <p>C. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 11-10-13 to 1-8-14 that states, "SN [skilled nurse] 1</p>						

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N000543	<p>w 9 [1 time per week for 9 weeks]."</p> <p>A. The record failed to evidence a SN visit had been provided the week of 11-10-13.</p> <p>B. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>6. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "The goal of the organization is to develop an individualized plan of care for every client in conjunction with their attending/treating physician and to provide our clients with services and care consistent with their plan . . . All care and services provided is according to current physician orders." 410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse had initiated nursing procedures for the assessment and care</p>	N000543	N543Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and	02/27/2014	

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	<p>of patients in 3 (#s 3, 6, and 7) of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services.</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 12-13-13 to 2-10-14. The plan of care states, "SN to instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p> <p>A. The record failed to evidence the registered nurse had initiated appropriate nursing interventions to address the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant</p>		<p>Educator regarding policy # 33.08 Nursing Service and policy # 33.24 Plan of Care and Physician Orders. Education was provided related to initiation of preventive and rehabilitative nursing procedures to address care of the patient. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center and nursing interventions clarified on 1-23-14. Clarification with physician on 2-18-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor provision of nursing care for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>with the ordered diet and had blood glucose readings above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non compliance" with the prescribed diet and that the patient's blood sugar reading was 209. The note states, "Patient states had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p> <p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p> <p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p>						

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	<p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt doesn't follow diet."</p> <p>2. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>A. The record failed to evidence the registered nurse had initiated and/or implemented any preventative nursing interventions related to the care of the patient's dialysis access site.</p> <p>B. During a home visit to patient number 6, on 1-23-14 at 10:30 AM, the patient stated, "I have had to tell them [agency staff] not to take a blood pressure in my left arm."</p> <p>3. During a home visit to patient number 7, on 1-23-14 at 1:05 PM with employee H, a registered nurse, the</p>						

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	<p>patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had initiated and/or implemented any preventative nursing interventions related the care of the patient's central venous catheter or the maturing fistula.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p>				

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record review and interview, the registered nurse failed to ensure coordination of services among agency staff and with other health care providers had occurred in 3 (#s 6, 7, and 8) of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a start of care comprehensive assessment dated 1-9-14 that identified the patient received dialysis. The record included a start of care comprehensive assessment dated 1-9-14 that identified the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and that the patient had a "shunt left upper arm" for "dialysis."</p> <p>The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p>	N000545	<p>N545Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.20 Case Conference- Interdisciplinary Group Meeting/ Coordination of Service. Information regarding of coordination of services among agency staff and with other healthcare providers was included. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 6 - Transferred to hospital and discharged on 1-24-14. Patient # 7 - Coordination with dialysis center on 1-23-14. Clarification with physician on 2-18-14. No additional orders received. Patient # 8 - Discharged on 1-28-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor coordination of care and services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under</p>	02/27/2014

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	<p>2. During a home visit to patient number 7, on 1-23-14 at 1:05 PM, with employee H, a registered nurse, the patient indicated the patient received dialysis treatments 3 times per week for 3.5 hours on Mondays, Wednesdays, and Fridays. The patient indicated the presence of a central venous catheter and a maturing fistula in the left arm.</p> <p>A. The record included a recertification comprehensive assessment dated 12-24-13 that identifies the patient had "Hypertensive Chronic Kidney Disease, Unspecified with Chronic Kidney Disease State V or End Stage Renal Disease", and "Purpose of Intravenous Access . . . Dialysis."</p> <p>B. The record failed to evidence the registered nurse had coordinated care with the dialysis facility.</p> <p>3. Clinical record number 8 included a verbal order dated 12-21-13 that states, "OT [occupational therapy] eval and treat post hospitalization starting wk [week] 12-22-13." The record failed to evidence the OT evaluation had been completed.</p> <p>A. The record failed to evidence the registered nurse had coordinated with</p>		<p>the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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N000546	<p>the occupational therapist to ensure the OT evaluation had been completed.</p> <p>B. The Manager of Clinical Services, employee B, indicated the OT evaluation had not been completed as ordered when asked on 1-28-14 at 1:30 PM.</p> <p>4. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM and 1-29-14 at 10 AM.</p> <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 nurse had alerted the physician to changes in the patients' conditions in 1 (# 3) of 16 records reviewed creating the potential to affect all of the agency's 152 current patients that receive skilled nursing services.</p> <p>The findings include:</p>	N000546	N546Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional staff by the Director of Clinical Services (DCS) and Educator regarding policy # 33.24 Plan of Care and Physician Orders, Policy # 33.106 Comprehensive Assessment and OASIS Management and Policy and policy # 33.17 Medical Supervision. Education included	02/27/2014			

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	<p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 12-13-13 to 2-10-14. The plan of care states, "SN to instruct on diabetes including diabetes management, S/S [signs and symptoms] hyper/hypoglycemia and appropriate actions to take, teach diet restrictions, use of glucometer, administration of insulin, use of glucose log, S/S requiring notification of SN/Physician/911, and medications including purpose, S/E [side effects], and interactions." The plan of care evidenced the physician had ordered an 1800 calorie ADA diet.</p> <p>A. The record failed to evidence the nurse had notified the physician of the patient's noncompliance with the prescribed diet and elevated blood sugar readings.</p> <p>B. The record included skilled nurse (SN) visit notes that identified the patient was consistently non-compliant with the ordered diet and had blood glucose reading above the desired range of 70-110.</p> <p>1). A SN visit note dated 12-20-13 states "occasional non compliance" with the prescribed diet and that the patient's blood sugar reading</p>		<p>information that agency staff are to notify the physician with any change in condition. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 8 random clinical record reviews per month to monitor physician notification of a change in condition for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly record review. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>was 209. The note states, "Patient states had orange juice last night before bed." The note identified the prescribed diet as an "ADA" diet.</p> <p>2). A SN visit note dated 12-27-13 states the patient is "noncompliant" with the prescribed diet.</p> <p>3). A SN visit note dated 12-31-13 states a "reg [regular] no conc [concentrated] sweet" diet has been prescribed and that the patient is "noncompliant." The note states, "patient eats sweets and between meals." The note evidenced the patient's blood sugar reading was 373.</p> <p>4). A SN visit note dated 1-7-14 identifies a regular diet has been ordered and that the patient is compliant. The note evidenced the patient's blood sugar reading is 204 and that the "pt [patient] snacking on potato chips upon SN arrival."</p> <p>5). A SN visit note dated 1-14-14 identifies the patient is on a low sodium ADA diet, that the patient is "noncompliant", and that the blood sugar reading was 174. The note states, "Pt [patient] doesn't follow diet."</p> <p>2. The Manager of Clinical Services,</p>			

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N000567	<p>employee B, was unable to provide any additional documentation and/or information when asked on 1-28-14 at 1:30 PM.</p> <p>3. The agency's 4-28-08 "Plan of Care and Physician Orders" policy number 33.24 states, "Clinicians are responsible for alerting the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on clinical record and agency policy review and interview, the agency failed to ensure the qualified physical therapist consulted with the physician regarding the discontinuation of therapy services in 1 (#11) of 11 records reviewed of patients that received physical therapy (PT) services creating the potential to affect all of the agency's 88 current patients that receive PT services.</p> <p>The findings include:</p> <p>1. Clinical record number 11 included a verbal order dated 1-12-14 that</p>	N000567	N567Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Therapy staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.09 Physical Therapy Services and included education regarding physician consultation by the qualified physical therapist regarding discontinuation of services. Educational packets mailed to all Professional Therapy staff that were unable to attend the in-service on 2-17-14. Patient # 11 - Discharged 1-27-14. To ensure compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per	02/27/2014			

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	<p>evidenced PT services were to be provided 2 times per week for 3 weeks for therapeutic exercises, establishment of a home exercise program, and gait/balance training activities.</p> <p>A. The record included a PT visit note, signed and dated by the physical therapy assistant, employee M, on 1-21-14. The visit note states, "D/C [discontinue] home care physical therapy with OT [occupational therapy] and nurse to continue treatment."</p> <p>B. The record failed to evidence the qualified physical therapist had consulted with the physician regarding the discontinuation of the PT services.</p> <p>2. The Manager of Clinical Services, employee B, was unable to provide any additional documentation and/or information when asked on 1-29-14 at 10:00 AM and 12:40 PM.</p> <p>3. The agency's 4-4-13 "Physical Therapy Services" policy number 33.09 states, "The duties of the therapist include the following . . . Communicates with the physician regarding the evaluation of patient functional levels . . . Advises and consults with patients and patient families and other home health care staff members."</p>		<p>month to monitor therapy services for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	

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N000570	<p>410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may:</p> <p>(1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate.</p> <p>Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 5 (#s 3, 5, 7, 13, and 15) of 11 records reviewed of patients that received services from the PTA creating the potential to affect all of the agency's 88 current patients that receive physical therapy services.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist or physician is on the premises to provide</p>	N000570	N570Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional Therapy Staff by the Director of Clinical Services (DCS) and Educator regarding policy# 33.10 Physical Therapy Assistant Services and policy# 33.09 Physical Therapy Services. Education was provided regarding services furnished by a qualified physical therapy assistant and the required supervision and documentation of supervision by a qualified physical therapist. Educational packets mailed to all Professional staff that were unable to attend the in-service on 2-17-14. Patient # 3 – Discharged 2-10-14. Patient # 5 - Discharged on 2-6-14. Patient # 7 - Process instituted 2-11-14 for documentation of daily supervision of PTA by qualified Physical Therapist. Patient 13 - Discharged 1-29-14. Patient 15 - Discharged 10-28-13. To ensure compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per month to monitor therapy services and supervision of PTA by qualified	02/27/2014			

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	<p>constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments."</p> <p>2. The agency's 4-4-13 "Physical Therapy Services" policy number 33.09 states, "All physical therapy services offered directly or under contractual arrangements are provided by or under the supervision of a qualified physical therapist, in accordance with physician plan of treatment . . . The duties of the therapist include the following: . . . Supervises and evaluated care rendered by Physical Therapy Assistant. Cosigns all clinical documentation as required."</p> <p>3. Clinical record number 3 evidenced physical therapy services had been ordered by the physician 2 times per week during the certification period 12-13-13 to 2-10-14 and that the physical therapy services had been discontinued on 1-3-14. The record evidenced the PTA, employee N, had provided services to the patient on 12-19-13, 12-20-13, 12-24-13, 12-27-13, and 12-30-13.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist to review this patient's</p>		<p>physical therapist for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>treatment at least once each working day. The PTA visit notes, dated 12-19-13, 12-20-13, 12-24-13, 12-27-13, and 12-30-13, evidenced the supervising physical therapist, employee K, had reviewed and signed the notes on 1-16-14, 13 days after the physical therapy had been discontinued.</p> <p>4. Clinical record number 5 evidenced physical therapy services had been ordered by the physician 4 times per week for 1 week, 5 times per week for 1 week, and 3 times per week for 2 weeks during the certification period 1-13-14 to 3-13-14. The record evidenced the PTA, employee M, had provided services to the patient on 1-15-14 and 1-17-14 and that another PTA, employee N, had provided services on 1-20-14, 1-21-14, and 1-23-14.</p> <p>A. The record failed to evidence the PTAs had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes, dated 1-15-14 and 1-17-14, evidenced the supervising physical therapist, employee O, had reviewed and signed the note on 1-20-14, 3 and 5 days after the care had been provided.</p> <p>B. The 1-20-14, 1-21-14, and</p>						

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	<p>1-23-14 PTA visit notes failed to evidence any supervising physical therapist had reviewed the care provided to the patient and had co-signed the visit note.</p> <p>5. Clinical record number 7 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 3 weeks during the certification period 12-25-13 to 2-22-14. The record evidenced the PTA, employee M, had provided services to the patient on 12-27-13, 12-31-13, 1-7-14, 1-9-14, and 1-14-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes evidenced the supervising physical therapist, employee K, had reviewed and signed the notes on 1-16-14, 2 to 14 days after the services had been provided.</p> <p>6. Clinical record number 13 evidenced physical therapy services had been ordered by the physician 1 time per week for an evaluation and then 1 time per week for 1 week and 2 times per week for 2 weeks during the</p>			

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	<p>certification period 1-14-14 to 3-14-14. The record evidenced the PTA, employee M, had provided services to the patient on 1-23-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit note evidenced the supervising physical therapist, employee O, had reviewed and co-signed the note on 1-27-14, 4 days after the service had been provided.</p> <p>7. Clinical record number 15 evidenced physical therapy services had been ordered by the physician 2 times per week for 3 weeks, 1 time per week for 1 week, then 2 times per week for 3 weeks and 1 time per week for 1 week, then 1 time per week for 1 week and 2 times per week for 3 weeks. The record evidenced the PTA, employee I, provided services to the patient on 8-14-13, 8-19-13, 8-26-13, 9-11-13, 9-16-13, and 9-18-13.</p> <p>A. The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment. The PTA visit notes dated 8-14-13 and 8-19-13 evidenced the</p>						

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	<p>supervising physical therapist, employee O, had reviewed and co-signed the visit notes on 8-22-13, 3 to 8 days after the services had been provided.</p> <p>B. The 8-26-13 PTA visit note evidenced the supervising physical therapist, employee O, had reviewed the care and co-signed the note on 8-29-13, 3 days after the care had been provided.</p> <p>C. The 9-11-13, 9-16-13, and 9-18-13 PTA visit notes evidenced the supervising physical therapist, employee O, had reviewed the care and co-signed the visit notes on 10-1-13, 12 to 19 days after the care had been provided.</p> <p>8. The Administrator, employee A, indicated, on 1-29-14 at 10 AM, the physical therapists and the physical therapy assistants meet every morning at the agency. The Administrator indicated the PTA visit notes did not evidence the supervising physical therapists had reviewed each patient's treatment.</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME CARE SERVICES OF VINCENNES IN				STREET ADDRESS, CITY, STATE, ZIP CODE 413 N FIRST ST VINCENNES, IN 47591			
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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed an on-site visit to the patient's home at least every 2 weeks as required by agency policy in 1 (# 14) of 6 records reviewed of patients that received both skilled services and home health aide services from the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 14 evidenced skilled nursing services had been provided 1 time per month for 2 months and home health aide services had been provided 3 times per week during the certification period 12-1-13 to 1-29-14. The record failed to evidence the RN had completed an on-site supervisory visit at least every 2 weeks during the month of December 2013.</p> <p>A. The record evidenced the SN had completed a supervisory visit on 12-10-13 and not again until 1-8-14.</p>	N000606	<p>N606Mandatory inservices were held on 2-11-14, 2-13-14, 2-14-14, and 2-17-14 for Professional/Para Professional/Scheduling staff by the Director of Clinical Services (DCS) and Educator regarding Policy # 33.16 Supervision of Para Professionals. Education included information that on site supervisory visits are completed at least every two weeks. Educational packets mailed to all Professional/Para Professional/Scheduling staff that were unable to attend the in-service on 2-17-14. Patient # 14 - Notified physician on 1-29-14 of the change in the plan of care. To ensure compliance with the above policies and procedures the DCS or designee will conduct 5 random chart reviews per month to monitor supervisory visits for 3 months starting week of 2-23-14 and then ongoing as part of the agency quarterly chart reviews. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and</p>	02/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157217	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
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	<p>B. The Manager of Clinical Services, employee B, indicated, on 1-29-14 at 12:40 PM, the RN had not completed a supervisory visit at least every 2 weeks. The Manager stated, "The RN attempted a visit on 12-24 but the patient was not at home. I don't know if she attempted any other time during the week to make the visit."</p> <p>2. The agency's 7-10-13 "Supervision of Paraprofessionals" policy number 33.16 states, "State licensure and regulations - Aide with a skill. Once a month but to comply with Medicare they must be done q [every] 2 weeks. Aide may or may not be present."</p>		Regional Vice President.		