

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2012
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NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902
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G0000	<p>This was a federal home health complaint investigation survey.</p> <p>Complaint numbers: IN00105516 and IN105198 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey date: April 9, 2012</p> <p>Facility number: 011284</p> <p>Medicaid vendor number: 200849420</p> <p>Surveyors: Bridget Boston, RN, Public Health Nurse Surveyor - team leader Tonya Tucker, RN, Public Health Nurse Surveyor</p> <p>Census: skilled 344 aide only 40</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 13, 2012</p>	G0000		

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

TITLE

(X6) DATE

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

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G0108	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record and policy review and interview, the agency failed to provide inform the patient of the change in the plan of care and the intent of the agency to discharge the patient for 1 of 9 closed clinical records reviewed. (1)</p> <p>Findings include:</p> <p>1. Clinical Record # 1, start of care 10/26/11, evidenced a plan of care beginning 2/23/12 through 4/22/12 with orders for a skilled nurse beginning the week of 3/4/12 "1W1, 1Q2WK2, 1Q3WK3, 1WK1" [one time during the first week, then one time every 2 weeks for 2 weeks, then one time every 3 weeks for 3 weeks, and then one time for one week] for a total of 7 weeks of nursing service. The POC included an order for</p>	G0108	G108 - Changes to the plan of care The Regional Director has in-serviced all field & office clinicians of the requirements to inform the patient of any changes to the plan of care. Training included the correct use of HHABN's to inform patient's that services are ending and obtaining a physician order to discontinue any remaining services at the time of discharge. (See Exhibits A, B & C) An updated discharge approval process will be required to assure that the client, physician and agency are in agreement with all discharges prior to the actual discharge occurring. (See Exhibit C) This process requires that a discharge note be written by the clinical supervisor to document approval of all patient discharges. (See Exhibit D)The discharge approval note will ensure that all actions are taken to assure that an HHABN has been served if indicated, the	05/04/2012	

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	<p>an occupational therapist (OT) evaluation, and a home health aide "1 WK1, 4WK8" one time during the first week of the certification period and then four times a week during the remaining 8 weeks for a total of nine weeks.</p> <p>A. The OT evaluation was completed on 2/27/12 and a physician order was received to provide OT services one time for the first week and then twice a week for the next 3 weeks for a total of 4 weeks. The clinical record evidenced the last visit made by the occupational therapist was 3/21/12 fulfilling the order for four weeks of service.</p> <p>B. The clinical record evidenced skilled nurse services were provided on 3/6/13 and 3/13/12. The clinical record evidenced a physician order dated 3/8/12 that stated, "Problem: Patient progressing well toward toward nursing goals. Intervention: DC skilled nurse nursing service at subsequent visit." The record evidenced the skilled nurse made a skilled nurse visit on 3/13/12, outside the POC orders of "1Q2WK2." The skilled visit note dated 3/13/12 was titled "DC OF SN SERVICES (NOT FROM AGENCY)."</p> <p>C. The clinical record evidenced a document titled "Home Health Advance Beneficiary Notice" dated March 13,</p>		<p>patient is aware of discharge, the physician is notified and a 5-day notice has been given. (See Exhibit A) The QA Nurse will audit 50% of all agency discharges for 8 weeks with a threshold of 95% weekly to ensure that the discharge approval process was completed and all necessary actions were taken including physician notification of the discharge. (See Exhibit E & F). Once 95% completion of discharge approval has been maintained for a 4 week period it will be reduced to 10% of all patients discharged for 4 weeks and if 95% completion continues to be maintained this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit G) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>		

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	<p>2012, and signed by the patient that stated, "We, Great Lakes Caring, your home health agency, are letting you know that nursing services will no longer be provide you with the following items and / or services. Because: No Skilled Need."</p> <p>D. The clinical record evidenced the patient received aide services four times a week and the last aide visit was made on 3/21/12.</p> <p>E. The clinical record failed to evidence a physician order for the discontinuation of the home heath aide services prior to the end of the certification period and that the patient was notified at least 5 days prior to the discontinuation of the services.</p> <p>2. On 4/9/12 at 3:49 PM, employee B indicated the clinical record for patient # 1 failed to evidence written documentation the patient was informed of the intent of discharge from the agency.</p> <p>3. The policy titled "Client discharge Policy" stated, "In the state of Indiana a minimum of 5 days notice is required prior to services being terminated."</p>				

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy and clinical record review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 2 of 2 (patient 1 and 2) clinical records reviewed of patients with orders for home health aide services creating the potential for treatment omission and patient harm to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical Record # 1, start of care 10/26/11, evidenced a plan of care beginning 2/23/12 through 4/22/12 with orders for a skilled nurse beginning the week of 3/4/12 "1W1, 1Q2WK2, 1Q3WK3, 1WK1" [one time during the first week, then one time every 2 weeks for 2 weeks, then one time every 3 weeks for 3 weeks, and then one time for one week] for a total of 7 weeks of nursing service. The POC included an order for a home health aide "1 WK1, 4WK8" one time during the first week of the certification period and then four times a week during the remaining 8 weeks for a total of nine weeks.</p>	G0158	G158 The Regional Director in-serviced all field staff and office clinicians on the Plan of Care policy that requires staff to promptly alert the physician to any changes that suggest a need to alter the plan of care. (See Exhibit A) The Regional Director also in-serviced field and office clinicians on the frequency policy and regulation requiring home health agencies to alert the physician to any changes that suggest a need to alter the plan of care and the home health agency must maintain documentation indicating that the physician was notified and is aware of the missed visit. (See Exhibit H) The Regional Director or designee will audit 25% of orders for accuracy of frequency and duration for 4 weeks with a threshold of 95%. Once the 95% threshold has been maintained for 4 weeks, the number of audits will be dropped to 10% weekly for 4 weeks. If 95% has been maintained the weekly audits will be stopped and this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit I) The Regional Director or designee will audit 25% of missed visits for physician notification for	05/04/2012			

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	<p>A. The clinical record evidenced skilled nurse services were provided on 3/6/13 and 3/13/12. The clinical record evidenced a physician order dated 3/8/12 that stated, "Problem: Patient progressing well toward nursing goals. Intervention: DC skilled nurse nursing service at subsequent visit." The record evidenced the skilled nurse made a skilled nurse visit on 3/13/12, outside the POC orders of "1Q2WK2." The skilled visit note dated 3/13/12 was titled "DC OF SN SERVICES (NOT FROM AGENCY)."</p> <p>B. The clinical record evidenced a document titled "Home Health Advance Beneficiary Notice" dated March 13, 2012 and signed by the patient stated, "We, Great Lakes Caring, your home health agency, are letting you know that nursing services will no longer be provide you with the following items and / or services. Because: No Skilled Need."</p> <p>C. The clinical record evidenced the patient received aide services four times a week and the last aide visit was made on 3/21/12. The clinical record failed to evidence a physician order for the discontinuation of the home heath aide services prior to the end of the certification period.</p>		4 weeks with a threshold of 95%. Once the 95% threshold has been maintained for 4 weeks the number of audits will be dropped to 10% weekly for 4 weeks. If 95% has been maintained the weekly audits will be stopped and this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit J) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	<p>D. On 4/9/12 at 3:49 PM, employee B indicated the clinical record for patient # 1 failed to evidence an order to discontinue the home health aide services.</p> <p>2. Clinical record # 2, start of care 4/18/10, included a plan of care established by the physician for the certification period 2/7/12 through 4/6/12 with orders for home health aide 2 times a week for week one of the certification period and three times a week for the remaining 8 weeks of the certification period.</p> <p>A. The clinical record failed to evidence the patient received three home health aide visits during week three of the certification period, February 19 through the 25, 2012. The clinical record evidenced visits were made on February 22 and 24, 2012. The record failed to evidence the physician was notified of the missed visit.</p> <p>B. On 4/9/12 at 2:32 PM, employee B indicated that there was not a missed visit note to explain why the patient did not receive all home health aide visits ordered during week three of the certification period.</p>						

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	3. The undated policy titled "Frequencies" stated, "The regulation requires the home health agencies to alert the physician to any changes that suggest a need to alter the plan of care. If the home health agency provides fewer visits that the physician orders, it has altered the plan of care and the physician must be notified. The home health agency must maintain documentation in the clinical record indicating that the physician was notified and is aware of the missed visit."			

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N0488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on clinical record and policy review and interview, the agency failed to provide the patient with a 5 day notice of discharge for 1 of 9 closed clinical records reviewed. (1)</p> <p>Findings include:</p> <p>1. Clinical Record # 1, start of care</p>	N0488	The Regional Director has in-serviced all field & office clinicians of the requirements to inform the patient of any changes to the plan of care. Training included the correct use of HHABN's to inform patient's that services are ending and obtaining a physician order to discontinue any remaining services at the time of discharge. (See Exhibits	05/04/2012			

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	<p>10/26/11, evidenced a plan of care beginning 2/23/12 through 4/22/12 with orders for a skilled nurse beginning the week of 3/4/12 "1W1, 1Q2WK2, 1Q3WK3, 1WK1" [one time during the first week, then one time every 2 weeks for 2 weeks, then one time every 3 weeks for 3 weeks, and then one time for one week] for a total of 7 weeks of nursing service. The POC included an order for an occupational therapist (OT) evaluation, and a home health aide "1 WK1, 4WK8" one time during the first week of the certification period and then four times a week during the remaining 8 weeks for a total of nine weeks.</p> <p>A. The OT evaluation was completed on 2/27/12 and a physician order was received to provide OT services one time for the first week and then twice a week for the next 3 weeks for a total of 4 weeks. The clinical record evidenced the last visit made by the occupational therapist was 3/21/12 fulfilling the order for four weeks of service.</p> <p>B. The clinical record evidenced skilled nurse services were provided on 3/6/13 and 3/13/12. The clinical record evidenced a physician order dated 3/8/12 that stated, "Problem: Patient progressing well toward toward nursing goals. Intervention: DC skilled nurse nursing</p>		<p>A, B & C) An updated discharge approval process will be required to assure that the client, physician and agency are in agreement with all discharges prior to the actual discharge occurring. (See Exhibit C) This process requires that a discharge note be written by the clinical supervisor to document approval of all patient discharges. (See Exhibit D)The discharge approval note will ensure that all actions are taken to assure that an HHABN has been served if indicated, the patient is aware of discharge, the physician is notified and a 5-day notice has been given. (See Exhibit A) The QA Nurse will audit 50% of all agency discharges for 8 weeks with a threshold of 95% weekly to ensure that the discharge approval process was completed and all necessary actions were taken including physician notification of the discharge. (See Exhibit E & F). Once 95% completion of discharge approval has been maintained for a 4 week period it will be reduced to 10% of all patients discharged for 4 weeks and if 95% completion continues to be maintained this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit G) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.</p>				

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	<p>service at subsequent visit." The record evidenced the skilled nurse made a skilled nurse visit on 3/13/12, outside the POC orders of "1Q2WK2." The skilled visit note dated 3/13/12 was titled "DC OF SN SERVICES (NOT FROM AGENCY)."</p> <p>C. The clinical record evidenced a document titled "Home Health Advance Beneficiary Notice" dated March 13, 2012, and signed by the patient that stated, "We, Great Lakes Caring, your home health agency, are letting you know that nursing services will no longer be provide you with the following items and / or services. Because: No Skilled Need."</p> <p>D. The clinical record evidenced the patient received aide services four times a week and the last aide visit was made on 3/21/12.</p> <p>E. The clinical record failed to evidence a physician order for the discontinuation of the home heath aide services prior to the end of the certification period and that the patient was notified at least 5 days prior to the discontinuation of the services.</p> <p>2. On 4/9/12 at 3:49 PM, employee B indicated the clinical record for patient # 1 failed to evidence written documentation the patient was informed</p>				

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	of the intent of discharge from the agency. 3. The policy titled "Client discharge Policy" stated, "In the state of Indiana a minimum of 5 days notice is required prior to services being terminated."				

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on policy and clinical record review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 2 of 2 (patient 1 and 2) clinical records reviewed of patients with orders for home health aide services creating the potential for treatment omission and patient harm to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical Record # 1, start of care 10/26/11, evidenced a plan of care beginning 2/23/12 through 4/22/12 with orders for a skilled nurse beginning the week of 3/4/12 "1W1, 1Q2WK2, 1Q3WK3, 1WK1" [one time during the first week, then one time every 2 weeks for 2 weeks, then one time every 3 weeks for 3 weeks, and then one time for one week] for a total of 7 weeks of nursing service. The POC included an order for a home health aide "1 WK1, 4WK8" one time during the first week of the certification period and then four times a week during the remaining 8 weeks for a total of nine weeks.</p>	N0522	<p>The Regional Director in-serviced all field staff and office clinicians on the Plan of Care policy that requires staff to promptly alert the physician to any changes that suggest a need to alter the plan of care. (See Exhibit A) The Regional Director also in-serviced field and office clinicians on the frequency policy and regulation requiring home health agencies to alert the physician to any changes that suggest a need to alter the plan of care and the home health agency must maintain documentation indicating that the physician was notified and is aware of the missed visit. (See Exhibit H) The Regional Director or designee will audit 25% of orders for accuracy of frequency and duration for 4 weeks with a threshold of 95%. Once the 95% threshold has been maintained for 4 weeks, the number of audits will be dropped to 10% weekly for 4 weeks. If 95% has been maintained the weekly audits will be stopped and this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit I) The Regional Director or designee will audit 25% of missed visits for physician notification for 4 weeks with a threshold of 95%.</p>	05/04/2012			

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	<p>A. The clinical record evidenced skilled nurse services were provided on 3/6/13 and 3/13/12. The clinical record evidenced a physician order dated 3/8/12 that stated, "Problem: Patient progressing well toward toward nursing goals. Intervention: DC skilled nurse nursing service at subsequent visit." The record evidenced the skilled nurse made a skilled nurse visit on 3/13/12, outside the POC orders of "1Q2WK2." The skilled visit note dated 3/13/12 was titled "DC OF SN SERVICES (NOT FROM AGENCY)."</p> <p>B. The clinical record evidenced a document titled "Home Health Advance Beneficiary Notice" dated March 13, 2012 and signed by the patient stated, "We, Great Lakes Caring, your home health agency, are letting you know that nursing services will no longer be provide you with the following items and / or services. Because: No Skilled Need."</p> <p>C. The clinical record evidenced the patient received aide services four times a week and the last aide visit was made on 3/21/12. The clinical record failed to evidence a physician order for the discontinuation of the home heath aide services prior to the end of the certification period.</p>		Once the 95% threshold has been maintained for 4 weeks the number of audits will be dropped to 10% weekly for 4 weeks. If 95% has been maintained the weekly audits will be stopped and this will become a quarterly process of 10% of all charts will be reviewed. (See Exhibit J) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/09/2012
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	<p>D. On 4/9/12 at 3:49 PM, employee B indicated the clinical record for patient # 1 failed to evidence an order to discontinue the home health aide services.</p> <p>2. Clinical record # 2, start of care 4/18/10, included a plan of care established by the physician for the certification period 2/7/12 through 4/6/12 with orders for home health aide 2 times a week for week one of the certification period and three times a week for the remaining 8 weeks of the certification period.</p> <p>A. The clinical record failed to evidence the patient received three home health aide visits during week three of the certification period, February 19 through the 25, 2012. The clinical record evidenced visits were made on February 22 and 24, 2012. The record failed to evidence the physician was notified of the missed visit.</p> <p>B. On 4/9/12 at 2:32 PM, employee B indicated that there was not a missed visit note to explain why the patient did not receive all home health aide visits ordered during week three of the certification period.</p>				

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	3. The undated policy titled "Frequencies" stated, "The regulation requires the home health agencies to alert the physician to any changes that suggest a need to alter the plan of care. If the home health agency provides fewer visits that the physician orders, it has altered the plan of care and the physician must be notified. The home health agency must maintain documentation in the clinical record indicating that the physician was notified and is aware of the missed visit."			