

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2012
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NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311
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G0000	<p>This was a revisit for a federal home health agency recertification survey that was conducted June 18, 2012, that resulted in an extended survey.</p> <p>Survey date: August 2, 2012</p> <p>Facility #: 007377</p> <p>Medicaid #: 200873250</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>During this survey, one condition of participation and twenty seven standard level deficiencies were corrected, one standard level deficiency was recited, and three new standard level deficiencies were cited.</p> <p>Incare Home Healthcare, Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of two years beginning June 18, 2012, to June 18, 2014, due to being found out of compliance with the Condition of Participation 42 CFR 484.10 Patient Rights.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	G0000	N 000 The Administrator and Supervisor in-serviced the home health aides for atleast 12 hours annually within the scope of services of Home Health Aide and with the following subject like the communication skills, observing, reporting and documenting patient status, reading and recording temperature, pulse and respiration, basic infection control procedures, monitoring a clean, safe and healthy environment, recognizing emergencies and knowledge of emergency procedures and the physical, emotional and developmental need of ways to work with the population served by the home health agency. The Administrator and supervisor will monitor that the deficiency is corrected and will not recur.	

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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	August 8, 2012				

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G0157	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on clinical record and policy review and interview, the agency failed to ensure the patient's needs were adequately met in the home in 3 of 3 records reviewed with the potential to affect all the agency's patients. (# 20, 21, and 22)</p> <p>The findings include:</p> <p>1. Clinical record 20 evidenced a referral for home health services from the assisted living facility in which the patient resided dated 7/26/12 that stated, "Order - home care with PT / OT d/t [due to] falls." The clinical record included a plan of care for the certification period 7/27/12 through 9/24/12 and the principle diagnosis "Lumbago" and other pertinent diagnosis of "Abnormality of Gait" and "Muscle weakness - general." The plan of care failed to evidence an order for PT and / or OT. The clinical record evidenced the patient was in the emergency room of LaPorte Hospital on 7/26/12 for complaints of back pain.</p> <p>A. The record evidenced the</p>	G0157	<p>G 0157 The Administrator and Supervisor have in-serviced regarding the plan of care should include the order for Physical Therapy and or Occupational Therapy whether the referral coming from assisted living facility or other facilities. The Administrator and supervisor will monitor that the deficiency is corrected and will not recur. A - The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. B - The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. 1.</p>	08/23/2012			

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	<p>comprehensive assessment was completed by employee BB on 7/27/12 and included a "Fall Risk" and the score obtained was 50 points. The assessment form stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: ... 2. Refer to Physical Therapy and / or Occupational Therapy."</p> <p>B. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12, completed by a contracted therapist. Employee C indicated the OT evaluation determined the patient did not need OT and the patient did not receive any OT services. Employee C also indicated she had not yet obtained an order and contacted any physical therapist to evaluate the patient.</p> <p>2. Clinical record 21 evidenced a verbal order for home health services dated 7/6/12 and included a plan of care for the certification period 7/17/12 through 9/14/12. The principle diagnosis was "Lumbago" and other pertinent diagnosis were "Blindness / low vision, asthma, and Muscle Weakness - general." The plan of care included an order for PT and / and OT to evaluate.</p> <p>On August 2, 2012, at 4 PM,</p>		<p>The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. 2 The Administrator and Supervisor have in-serviced staff regarding verbal orders for home health services and plan of care for Physical Therapy and Occupational Therapy to evaluate. The initial visit should be set up within 48 hours. If there is no visit then another order should be obtained as to why the initial visit was not done as well as obtained the order for Physician to discontinue the order to evaluate. 3. The Administrator and supervisor have in-serviced staff regarding Physical and Occupational Therapy evaluations. Physical and Occupational Therapist upon evaluation done, evaluation should be turned into the agency for documentation at the soonest possible time or a nurse can communicate with the Therapists for the evaluation documentation purposes.</p> <p>The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and</p>				

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	<p>employee C indicated, as of 8/2/12, the patient was not evaluated by a physical therapist and an occupational therapist for services. She indicated there was no documentation the physician was notified and there was not a physician order to discontinue the order to evaluate.</p> <p>3. Clinical record 22 included a plan of care for the certification period 7/24/12 through 9/21/12 with an order for PT and / and OT to evaluate. The record included a comprehensive assessment dated 7/24/12 and included a "Fall Risk" score of 75 points. The assessment stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: ... 2. Refer to Physical Therapy and / or Occupational Therapy."</p> <p>On August 2, 2012, at 4:08 PM, employee C presented for review a physical therapy evaluation and a PT visit note dated 7/24/12. She indicated she no other documentation was available.</p> <p>4. The undated policy titled "Patient Admission Process" # C - 140 and provided by employee C on 8/2/12 stated, "Purpose: To establish a consistent admission process for all patients ... Admission criteria ... The patients needs can safely and adequately be met in the</p>		Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.				

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure evaluations and instruction was completed as ordered on the plan of care in 3 (# 's 20, 21, and 22) 3 current records reviewed creating the potential to affect all of the agency's 144 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 20 included a medical plan of care (POC) for the certification period 7/27/12 through 9/24/12 with the admission diagnosis Lumbago, and other pertinent diagnosis of Diabetes Mellitus - type II, abnormality of gait, benign hypertension, and muscle weakness. The POC stated, "SN [skilled Nurse] 1 WK [one time a week] 10 WKS [for 10 weeks] ... Teach disease process, s/s [signs and symptoms] infection and standard precautions, diet, home safety / falls, prevention. ... Medication teaching." The record included a start of care initial comprehensive assessment dated 7/27/12 completed by employee BB, a registered nurse. The assessment failed to evidence an evaluation of the 	G0158	<p>G 0158 The Administrator and supervisor have inserviced with staff regarding the Plan of Care. Respective nurses should have a individual goals and plan of treatment and a short term and long term goals that would include in the plan of care of that patient. The Administrator and supervisor will monitor that the deficiency is corrected and will not recur. A The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. B. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the</p>	08/23/2012	

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	<p>patient's understanding of and ability to manage diabetes and pain, self administration of pain medication, and fall precautions.</p> <p>A. Clinical record 20 also evidenced a referral for home health services from the staff of the assisted living residence in which the patient resided dated 7/26/12. The record evidenced a comprehensive assessment was completed by employee BB and dated 7/27/12. The clinical record failed to evidence a verbal order was obtained for the skilled nurse visit and completion of the comprehensive assessment.</p> <p>B. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12 completed by a contracted occupational therapist. The clinical record failed to evidence an order for the occupational therapist evaluation and the treatment provided to the patient.</p> <p>C. On August 2, 2012 at 1 PM, employee C indicated there was no documentation or orders received by the home health agency for the skilled nurse and occupational therapist evaluations completed and the services they provided. She indicated the agency accepted the unsigned prescription, dated 7/26/12, sent</p>		<p>Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. C. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services.</p> <p>1. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or</p>		

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	<p>to the agency by the referring assisted living facility on 7/26/12 as the physician order for the home health services provided.</p> <p>2. Clinical record number 21 included a medical POC for the certification period 7/17/12 through 9/14/12 with the admission diagnosis Lumbago and other pertinent diagnosis that included - blindness / low vision, asthma, and muscle weakness. The POC stated, "SN [skilled Nurse] 1 WK [week] 9 WKS [weeks] ... Teach disease process, s/s infection and standard precautions, ... home safety / falls, prevention. Medication teaching." The POC included an order for OT [occupational therapist] and PT [physical therapist] to evaluate. The clinical record failed to evidence an assessment by a OT and PT.</p> <p>A. The record included a start of care initial comprehensive assessment dated 7/17/12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage pain, self administration of pain medication, and fall precautions.</p> <p>B. On August 2, 2012, at 4 PM, employee C indicated the patient was not evaluated by a OT and PT.</p>		<p>Occupational Therapist can do a visit for home health services.</p> <p>2. The Administrator and Supervisor have in-services staff regarding the Plan of Care which includes an order of the assessment done by the Physical and Occupational Therapists. It will also include the frequency and their goals for treatment.</p> <p>3. The Administrator and Supervisor have in-serviced staff regarding Plan of Care. Physical and Occupational Therapy with order for therapy to evaluate should turn in the evaluation documents to be included in the Plan of Care or Skilled nurse can communicate through phone to obtain in the Plan of Care.</p> <p>The administrator and Supervisor have in-serviced staff regarding the Plan of Care. Respective disciplines, Physical and Occupational Therapist and Skilled nurses, after initial visit should focus on interventions and frequency and duration based on the effectiveness of interventions and progress towards goals on the Plan of Care. Also, all treatments and services provided to patients must be ordered by a physician and may be initiated via telephone or in writing and must be counter-signed by the physician. All medication/treatment must be ordered by the physician and must be placed in the chart until the original is signed and returned.</p> <p>4. The administrator</p>		

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	<p>3. Clinical record 22 included a plan of care for the certification period 7/24/12 through 9/21/12 with an order for PT and / and OT to evaluate. The record failed to evidence an occupational therapy evaluation.</p> <p>On August 2, 2012, at 4:08 PM, employee C presented for review a physical therapy evaluation and a PT visit note dated 7/24/12. She indicated no other documentation was available.</p> <p>3. The undated policy titled "Care Plans" # C - 660 and provided by employee C on 8/2/12 stated, "Purpose: To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals."</p> <p>4. The undated policy titled "Physician Orders" # C 635, provided by employee C on 8/2/12 stated, "All ... treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... A copy of the order must be placed in the chart until the original is signed and returned."</p>		<p>and Supervisor have in-serviced staff regarding the Plan of Care. Respective disciplines, Physical and Occupational Therapist and Skilled nurses, after initial visit should focus on interventions and frequency and duration based on the effectiveness of interventions and progress towards goals on the Plan of Care. Also, all treatments and services provided to patients must be ordered by a physician and may be initiated via telephone or in writing and must be counter-signed by the physician. All medication/treatment must be ordered by the physician and must be placed in the chart until the original is signed and returned.</p> <p>The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.</p>				

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G0166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse obtained and documented verbal orders for the evaluation of the patient for home health services for 1 of 3 active clinical records reviewed with the potential to affect all patients served by the agency. (patient 20)</p> <p>The findings include:</p> <p>1. Clinical record 20 evidenced a referral for home health services from the staff of the assisted living residence in which the patient resided dated 7/26/12. The record evidenced a comprehensive assessment was completed by employee BB and dated 7/27/12. The clinical record failed to evidence a verbal order was obtained for the skilled nurse visit and completion of the comprehensive assessment.</p> <p>A. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12 completed by a contracted occupational</p>	G0166	G 0166 – 1. The Administrator and supervisor have inserviced with staff regarding the Plan of Care. Respective nurses should have a individual goals and plan of treatment and a short term and long term goals that would include in the plan of care of that patient. 2. The Administrator and Supervisor have in-serviced staff regarding Physician order. Respective disciplines such as Skilled Nurse should recognize a Physician order comprises that all treatment and services provided to patients must be ordered by a physician. The order may be initiated via telephone or in writing and must be countersigned by the Physician. All medications and treatments that are part. 1. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed	08/23/2012			

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	<p>therapist. The clinical record failed to evidence an order for the occupational therapist evaluation and the treatment provided to the patient.</p> <p>B. On August 2, 2012 at 1 PM, employee C indicated there was no documentation or orders received by the home health agency for the skilled nurse and occupational therapist evaluations completed and the services they provided. She indicated the agency accepted the unsigned prescription, dated 7/26/12, sent to the agency by the referring assisted living facility on 7/26/12 as the physician order for the home health services provided.</p> <p>2. The undated policy titled "Physician Orders" # C 635, provided by employee C on 8/2/12 stated, "All ... treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... A copy of the order must be placed in the chart until the original is signed and returned."</p>		<p>prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. A. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. B. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. C. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services.</p> <p>The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157596		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2012	
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G0332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record and policy review and interview, the agency failed to ensure the initial assessment visit was completed within 48 hours of referral for 1 of 3 clinical records reviewed with the potential to affect all of the agency's new admissions. (patient 21)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 21, start of care 7/17/12, evidenced a physician order for skilled nurse, physical and occupational therapy, and home health aide services dated 7/6/12. The initial Comprehensive Assessment was completed on 7/17/12. 2. On August 2, 2012, at 4 PM, employee C indicated the patient was not evaluated for services until 7/17/12 and the clinical record did not evidence why there was a delay in evaluating the patient. There was no documentation the physician was notified, and there was not a physician order to discontinue the 7/6/12 order. 3. The undated policy titled "Patient Admission Process" number C 140, and provided by employee C on 8/2/12 stated, 	G0332	<p>G 0332 – The Administrator and Supervisor have in-serviced staff regarding the initial assessment visit. Respective disciplines: Skilled Nurse, Physical and Occupational Therapies and Home Health Aides should have initial assessment visit within 48 hours of referral or on the physician ordered Start of Care date. If delayed occurs the physician should be notified for proper documentation or obtained an discontinuation for care for that certain discipline should be done and signed by the doctor. The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.</p>	08/23/2012			

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	"Each patient referred to the agency shall be evaluated by a registered nurse / therapist to determine immediate care and support needs ... The initial assessment will be completed within 48 hours."			

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N0000	<p>This was a revisit for a state home health agency re-licensure survey that was conducted on June 18, 2012.</p> <p>Survey date: August 2, 2012</p> <p>Facility #: 007377</p> <p>Medicaid #: 200873250</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>During this survey, twenty five standard level deficiencies were corrected, one standard level deficiency was recited, and two new standard level deficiencies were cited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 8, 2012</p>			N0000	<p>N 000 The Administrator and Supervisor in-serviced the home health aides for atleast 12 hours annually within the scope of services of Home Health Aide and with the following subject like the communication skills, observing, reporting and documenting patient status, reading and recording temperature, pulse and respiration, basic infection control procedures, monitoring a clean, safe and healthy environment, recognizing emergencies and knowledge of emergency procedures and the physical, emotional and developmental need of ways to work with the population served by the home health agency. The Administrator and supervisor will monitor that the deficiency is corrected and will not recur.</p>		

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N0520	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient's needs were adequately met in the home in 3 of 3 records reviewed with the potential to affect all the agency's patients. (# 20, 21, and 22)</p> <p>The findings include:</p> <p>1. Clinical record 20 evidenced a referral for home health services from the assisted living facility in which the patient resided dated 7/26/12 that stated, "Order - home care with PT / OT d/t [due to] falls." The clinical record included a plan of care for the certification period 7/27/12 through 9/24/12 and the principle diagnosis "Lumbago" and other pertinent diagnosis of "Abnormality of Gait" and "Muscle weakness - general." The plan of care failed to evidence an order for PT and / or OT. The clinical record evidenced the patient was in the emergency room of LaPorte Hospital on 7/26/12 for complaints of back pain.</p> <p>A. The record evidenced the</p>	N0520	N 0520 The Administrator and Supervisor have in-serviced regarding the plan of care should include the order for Physical Therapy and or Occupational Therapy whether the referral coming from assisted living facility or other facilities. A - The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. B. The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. 1. The Administrator and Supervisor have in-serviced staff regarding Occupational Therapist	08/23/2012			

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	<p>comprehensive assessment was completed by employee BB on 7/27/12 and included a "Fall Risk" and the score obtained was 50 points. The assessment form stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: ... 2. Refer to Physical Therapy and / or Occupational Therapy."</p> <p>B. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12, completed by a contracted therapist. Employee C indicated the OT evaluation determined the patient did not need OT and the patient did not receive any OT services. Employee C also indicated she had not yet obtained an order and contacted any physical therapist to evaluate the patient.</p> <p>2. Clinical record 21 evidenced a verbal order for home health services dated 7/6/12 and included a plan of care for the certification period 7/17/12 through 9/14/12. The principle diagnosis was "Lumbago" and other pertinent diagnosis were "Blindness / low vision, asthma, and Muscle Weakness - general." The plan of care included an order for PT and / and OT to evaluate.</p> <p>On August 2, 2012, at 4 PM,</p>		<p>and Physical Therapist whether contracted therapist or not. Upon admission if the patient has an order for Occupational Therapy and Physical Therapy, an order from the Physician should be received obtained within 48 hours from when the evaluation should be done. 2 The Administrator and Supervisor have in-serviced staff regarding verbal orders for home health services and plan of care for Physical Therapy and Occupational Therapy to evaluate. The initial visit should be set up within 48 hours. If there is no visit then another order should be obtained as to why the initial visit was not done as well as obtained the order for Physician to discontinue the order to evaluate. 3. The Administrator and supervisor have in-serviced staff regarding Physical and Occupational Therapy evaluations. Physical and Occupational Therapist upon evaluation done, evaluation should be turned into the agency for documentation at the soonest possible time or a nurse can communicate with the Therapists for the evaluation documentation purposes. The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this</p>				

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	<p>employee C indicated, as of 8/2/12, the patient was not evaluated by a physical therapist and an occupational therapist for services. She indicated there was no documentation the physician was notified and there was not a physician order to discontinue the order to evaluate.</p> <p>3. Clinical record 22 included a plan of care for the certification period 7/24/12 through 9/21/12 with an order for PT and / and OT to evaluate. The record included a comprehensive assessment dated 7/24/12 and included a "Fall Risk" score of 75 points. The assessment stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: ... 2. Refer to Physical Therapy and / or Occupational Therapy."</p> <p>On August 2, 2012, at 4:08 PM, employee C presented for review a physical therapy evaluation and a PT visit note dated 7/24/12. She indicated she no other documentation was available.</p> <p>4. The undated policy titled "Patient Admission Process" # C - 140 and provided by employee C on 8/2/12 stated, "Purpose: To establish a consistent admission process for all patients ... Admission criteria ... The patients needs can safely and adequately be met in the</p>		deficiency is corrected and will not recur.				

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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: Based on clinical record and policy review and interview, the agency failed to ensure evaluations and instruction was completed as ordered on the plan of care in 3 (# 's 20, 21, and 22) 3 current records reviewed creating the potential to affect all of the agency's 144 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 20 included a medical plan of care (POC) for the certification period 7/27/12 through 9/24/12 with the admission diagnosis Lumbago, and other pertinent diagnosis of Diabetes Mellitus - type II, abnormality of gait, benign hypertension, and muscle weakness. The POC stated, "SN [skilled Nurse] 1 WK [one time a week] 10 WKS [for 10 weeks] ... Teach disease process, s/s [signs and symptoms] infection and standard precautions, diet, home safety / falls, prevention. ... Medication teaching." The record included a start of care initial comprehensive assessment dated 7/27/12 completed by employee BB, a registered nurse. The assessment failed to evidence an evaluation of the</p>	N0522	N 0522 The Administrator and supervisor have inserviced with staff regarding the Plan of Care. Respective nurses should have a individual goals and plan of treatment and a short term and long term goals that would include in the plan of care of that patient. A The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. B. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a	08/23/2012			

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	<p>patient's understanding of and ability to manage diabetes and pain, self administration of pain medication, and fall precautions.</p> <p>A. Clinical record 20 also evidenced a referral for home health services from the staff of the assisted living residence in which the patient resided dated 7/26/12. The record evidenced a comprehensive assessment was completed by employee BB and dated 7/27/12. The clinical record failed to evidence a verbal order was obtained for the skilled nurse visit and completion of the comprehensive assessment.</p> <p>B. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12 completed by a contracted occupational therapist. The clinical record failed to evidence an order for the occupational therapist evaluation and the treatment provided to the patient.</p> <p>C. On August 2, 2012 at 1 PM, employee C indicated there was no documentation or orders received by the home health agency for the skilled nurse and occupational therapist evaluations completed and the services they provided. She indicated the agency accepted the unsigned prescription, dated 7/26/12, sent</p>		<p>Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. C. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. 2. The Administrator and Supervisor have in-services staff regarding the Plan of Care which includes an order of the assessment done by the Physical and Occupational Therapists. It will also include the frequency and their goals for treatment. 3. The Administrator and Supervisor have in-serviced staff regarding Plan of Care. Physical and Occupational Therapy with order for therapy to evaluate should turn in the evaluation documents to be included in the Plan of Care or Skilled nurse can communicate through phone to obtain in the Plan of Care. 3. The</p>		

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	<p>to the agency by the referring assisted living facility on 7/26/12 as the physician order for the home health services provided.</p> <p>2. Clinical record number 21 included a medical POC for the certification period 7/17/12 through 9/14/12 with the admission diagnosis Lumbago and other pertinent diagnosis that included - blindness / low vision, asthma, and muscle weakness. The POC stated, "SN [skilled Nurse] 1 WK [week] 9 WKS [weeks] ... Teach disease process, s/s infection and standard precautions, ... home safety / falls, prevention. Medication teaching." The POC included an order for OT [occupational therapist] and PT [physical therapist] to evaluate. The clinical record failed to evidence an assessment by a OT and PT.</p> <p>A. The record included a start of care initial comprehensive assessment dated 7/17/12. The assessment failed to evidence an evaluation of the patient's understanding of and ability to manage pain, self administration of pain medication, and fall precautions.</p> <p>B. On August 2, 2012, at 4 PM, employee C indicated the patient was not evaluated by a OT and PT.</p>		<p>administrator and Supervisor have in-serviced staff regarding the Plan of Care. Respective disciplines, Physical and Occupational Therapist and Skilled nurses, after initial visit should focus on interventions and frequency and duration based on the effectiveness of interventions and progress towards goals on the Plan of Care. Also, all treatments and services provided to patients must be ordered by a physician and may be initiated via telephone or in writing and must be counter-signed by the physician. All medication/treatment must be ordered by the physician and must be placed in the chart until the original is signed and returned. 4. The administrator and Supervisor have in-serviced staff regarding the Plan of Care. Respective disciplines, Physical and Occupational Therapist and Skilled nurses, after initial visit should focus on interventions and frequency and duration based on the effectiveness of interventions and progress towards goals on the Plan of Care. Also, all treatments and services provided to patients must be ordered by a physician and may be initiated via telephone or in writing and must be counter-signed by the physician. All medication/treatment must be ordered by the physician and must be placed in the chart until the original is signed and</p>				

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	<p>3. Clinical record 22 included a plan of care for the certification period 7/24/12 through 9/21/12 with an order for PT and / and OT to evaluate. The record failed to evidence an occupational therapy evaluation.</p> <p>On August 2, 2012, at 4:08 PM, employee C presented for review a physical therapy evaluation and a PT visit note dated 7/24/12. She indicated no other documentation was available.</p> <p>3. The undated policy titled "Care Plans" # C - 660 and provided by employee C on 8/2/12 stated, "Purpose: To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals."</p> <p>4. The undated policy titled "Physician Orders" # C 635, provided by employee C on 8/2/12 stated, "All ... treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... A copy of the order must be placed in the chart until the original is signed and returned."</p>		<p>returned.</p> <p>The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.</p>				

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N0547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse obtained and documented verbal orders for the evaluation of the patient for home health services for 1 of 3 active clinical records reviewed with the potential to affect all patients served by the agency. (patient 20)</p> <p>The findings include:</p> <p>1. Clinical record 20 evidenced a referral for home health services from the staff of the assisted living residence in which the patient resided dated 7/26/12. The record evidenced a comprehensive assessment was completed by employee BB and dated 7/27/12. The clinical record failed to evidence a verbal order was obtained for the skilled nurse visit and completion of the comprehensive assessment.</p> <p>A. On August 2, 2012, at 4:05 PM, employee C presented an occupational therapy assessment dated 7/30/12</p>	N0547	<p>N 0547 The Administrator and supervisor have inserviced with staff regarding the Plan of Care. Respective nurses should have a individual goals and plan of treatment and a short term and long term goals that would include in the plan of care of that patient. A . The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. B. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the</p>	08/23/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>completed by a contracted occupational therapist. The clinical record failed to evidence an order for the occupational therapist evaluation and the treatment provided to the patient.</p> <p>B. On August 2, 2012 at 1 PM, employee C indicated there was no documentation or orders received by the home health agency for the skilled nurse and occupational therapist evaluations completed and the services they provided. She indicated the agency accepted the unsigned prescription, dated 7/26/12, sent to the agency by the referring assisted living facility on 7/26/12 as the physician order for the home health services provided.</p> <p>2. The undated policy titled "Physician Orders" # C 635, provided by employee C on 8/2/12 stated, "All ... treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... A copy of the order must be placed in the chart until the original is signed and returned."</p>		<p>Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. C. The Administrator and Supervisor have in-serviced with staff regarding obtaining verbal order for skilled nurses, Physical and Occupational Therapists to do a visit as well as evationation for the completion of the Comprehensive Assessment and treatment to the patient. Also, upon receiving referral from a Assisted Living facility or other facilities for that matter, a signed prescription from the physician should be obtained before the skilled nurses or Physical or Occupational Therapist can do a visit for home health services. The Administrator and Supervisor have in-serviced staff regarding Physician order. Respective disciplines such as Skilled Nurse should recognize a Physician order comprises that all treatment and services provided to patients must be ordered by a physician. The order may be initiated via telephone or in writing and must be countersigned by the Physician. All medications and treatments that are part of the patients plan of care must be ordered by the physician. A copy</p>		

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			<p>of the order must be placed in the chart until the original is signed and returned.</p> <p>The Administrator and Supervisor will continue to have in-services, supervisory visits with each discipline including Skilled Nurse, Home Health Aide, Physical and Occupational Therapists and audit 10% of active patient charts monthly to monitor that the this deficiency is corrected and will not recur.</p>		