

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 9894 E 121ST ST FISHERS, IN 46037		
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G000000	<p>This was a federal home health recertification survey. This was a partially extended survey.</p> <p>Survey dates: 12/5/13 - 12/12/13</p> <p>Facility #: IN005265</p> <p>Medicaid #: 100272620A</p> <p>Surveyor: Ingrid Miller, RN, PHNS Janet Brandt, RN, PHNS</p> <p>Census service type: 6077 skilled unduplicated patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 19, 2013</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>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.</p> <p>Based on home visit observation, policy and procedure review, and interview, the agency failed to ensure employees (Employees I, K, D) followed agency policies and procedures related to infection control at 3 of 10 home visit observations (patient #1, 3, and 12) resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>1. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot by using an antiseptic gel to cleanse her hands and then attempted to don gloves. One glove fell on the floor. Employee I picked up the glove off the floor and donned it and the other glove. She then removed the patient's dressing and did not remove the dirty gloves. She readied her supplies by placing the scissors, the Aquacel Ag rope treatment package, and kerlix gauze on the floor. She then dressed the wound</p>	G000121	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Policies and procedures reviewed and revisions made. Provided education to staff involved in the cited visits. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Policies and procedures reviewed and revisions made. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Policy and procedure review indicated need to revise infection prevention policy and the Preparation of Work Area procedure. Education planned for all clinical staff to reeducate on policy/procedures indicated for infection prevention by 1/17/14Revision of field supervisory form to include infection prevention measures Describe how the corrective action(s) will be	01/17/2014			

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	<p>with these supplies.</p> <p>On 12/10/13 at 10:45 AM, Employee B, Registered Nurse, indicated visits observed with patient #1 failed to evidence infection prevention.</p> <p>2. On 12/9/13 at 11:05 AM, Employee K, physical therapist, was observed to change a compression dressing on patient #3's left leg and foot. This patient had a diagnosis of lymphedema in the lower extremities. (The other dressing was changed by skilled nursing due to a wound on the right leg.) She placed her computer and dressing supplies including kerlix and a protective wound ointment in a plastic tube on the floor. She removed the dressing from the patient's left leg and washed her hands and then applied the protective barrier ointment with ungloved hands. The patient's skin was dry and intact. She then proceeded to dress the patient's leg with the dressing supplies which had been placed on the floor.</p> <p>On 12/10/13 at 10:45 AM, Employee B, Registered Nurse, indicated visits observed with patient #3 failed to evidence infection prevention.</p> <p>3. On 12/9/13 at 11:05 AM, Employee D, LPN, was observed to care for patient #12, a patient with bilateral wounds</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with infection prevention measures. Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration</p>				

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	<p>around the axilla or armpits by applying a wound vac dressing under the right armpit. Patient #12 had visible blood on the skin after the wound care on the right arm pit was completed. The blood was visible on the right chest area, the right arm, and the right axillary area.</p> <p>Employee D touched the dressing with her bare hands on the dressing area. The wound dressing was clean and did not have visible blood on it. However, the skin around this area still had blood visible and had the potential to come in contact with the dressing under the right arm.</p> <p>On 12/9/13 at 12 noon, Employee W, RN, indicated blood was visible on the skin around the dressing area.</p> <p>4. The agency policy titled "Infection Prevention" with a review date of 3/8/13 stated, "Purpose: To protect individuals from transmission of communicable / infectious diseases ... infection: the transmission of a pathogenic microorganism to a host ... Modes of transmission in home care: indirectly on the healthcare personnel hands or contaminated equipment are some of the ways the infection can be spread ... Standard Precautions : Should be used during the care of patients whether or not the person is known to be infectious.</p>						

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	<p>Standard precautions are designed to reduce the risk of transmission from both recognized and unrecognized sources of infection. Standard precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions ... may contain transmissible infectious agents ... Clinical bag ... If you use a shoulder bag, you should select a flat hard surface to place the bag and set up work area. Use discretion and consideration when placing bag on patient's furniture ... CHH [Community Home Health] based on CDC guidelines ... b. If hands are not visibly soiled, use an alcohol - based hand rub for routinely decontaminating hands in all other clinical situations described in items C - J. Alternatively, wash hands with antimicrobial soap and water in all clinical situations described in items C - J ... C. decontaminate hands before having direct contact with patients ... decontaminate hands after removing gloves."</p> <p>5. The agency policy titled "Preparation of work area" with a date of 10/11 stated, "To prevent contamination of bag and equipment, avoid cross contamination, and establish a clean work area. Considerations ... as homes differ greatly, clinical staff will need to use judgement</p>			
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	<p>in selecting an appropriate work area ... Procedure: 1. Adhere to standard precautions. Select a flat surface to place bag and set up work area. Use discretion and consideration when placing bag on patient's furniture. Never place bag on floor ... Wash hands ... remove needed items from bag and place on clean surface or paper towel."</p>			

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G000145	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure a written summary was completed and sent to the physician every 60 days for 3 of 20 records reviewed (#3, 4, 16) with the potential to affect all the agency patients receiving services longer than 60 days.</p> <p>Findings</p> <p>Concerning no 60 day summary in the records</p> <p>1. Clinical record #4, start of care (SOC), failed to evidence the 60 day summary had been completed for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>On 12/12/13 at 12:05 PM, Employee BB, Registered Nurse, indicated there was no summary in the record.</p> <p>Concerning no 60 day summary sent to the physician</p> <p>2. Clinical record #3, SOC failed to evidence the 60 day summary had been</p>	G000145	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Records reviewed. The computer system needs updated to include needed patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The computer system needs updated to include patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Review Epic system for updates needed – by 1/3/14 Create Tips & Tricks for 60 Day Summary by 1/10/14 Educate Clinicians on 60 Day Summary process by 1/17/14 Educate HIM Auditors and Coders on the need to audit for 60 day summaries by	01/17/2014	

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	<p>sent to the physician for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>3. Clinical record #16, SOC failed to evidence the 60 day summary had been sent to the physician for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>4. On 12/12/13 at 12:25 PM, Employee BB indicated the summaries for clinical record #3 and #16 had not been sent to the attending physicians.</p> <p>5. The agency policy titled "Patient Progress / Summary Report" with an effective date of 4/2/12 stated, "A progress report is communicated to the physician at least every 60 days or more frequently if warranted ... the clinical findings will serve as the patient's progress summary."</p>		<p>1/17/14 Update HIM Auditor and Coders audit tool/process to include 60 day summaries by 1/17/14 Create the process for sending the physician the 60 Day summary by 1/17/14 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The executive director of quality and risk management and the homecare director are responsible for the audits/record reviews. The systems to be used for monitoring are the electronic medical record and benchmarking systems. February & March 2014 - Weekly 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance. Monthly Ongoing - 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance.</p>		

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, agency policy review, home visit observation, and interview, the agency failed to ensure visits and treatments had been provided in accordance with physician orders in 5 of 20 records reviewed (1, 6, 16, 19, 20) creating the potential to affect all the agency's current 823 patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 11/21/13 and diagnosis of pressure ulcer stage III, included a plan of care for the certification period of 11/21/13 - 1/19/14 which included orders to perform a general assessment and monitor and instruct in process and management of disease and all co-morbidities, signs and symptoms to report to MD, and to assess the patient for skin breakdown. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot and assess the right foot. The nurse did not assess the left foot or monitor the left foot for skin breakdown.</p>	G000158	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Discussion with each clinician involved to make sure that policy and procedure is understood. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Reviewed policies "Medical Supervision" and "Skilled Nursing Service" Reviewed LPN job description and scope of practice Correction plan established Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Planned education of clinicians for care planning, physician orders and visit schedules the week of Jan 13th, 2014 Record review tool revised to include compliance with plan of care Describe how the corrective action(s) will be monitored to ensure the deficient practice will	01/17/2014	

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	<p>2. Clinical record #6, SOC 3/31/13 and a diagnosis of non-healing surgical wound and morbid obesity, included a plan of care for the certification period of 11/26/13 - 1/24/13, with orders to perform a general assessment and to monitor and instruct in process and management of disease and co-morbidities and goals for the skilled nurse to assess palpable peripheral pulses. At a home visit on 12/9/13 at 3:10 PM, Employee E, Registered Nurse (RN), was observed to assess the patient's legs and noted edema around the cuffs of the patient's socks. She did not take the socks off and look at the feet or palpate the pedal pulses in the patient's feet.</p> <p>3. On 12/10/13 at 11:10 AM, Employee B, RN, indicated the feet were not assessed at the home visits noted for Clinical record #1 and Clinical record #6 in findings #1 and #2.</p> <p>4. Clinical record #16, SOC 9/26/13, included a plan of care for the certification period of 11/25/13 - 1/23/14. The plan of care failed to evidence orders for the physical therapist visits that were completed on 12/2/13 and 12/5/13.</p> <p>5. Clinical record #19, SOC 10/1/13, included a plan of care for the</p>		<p>not recur, i.e., what quality assurance program will be put into place. Record reviews to be completed monthly by clinical managers Health information management auditors complete routine audits that include compliance with ordered level of care Data analyzed to determine patterns/need for further corrective action. 5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with ordered plan of care. Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration.</p>				

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	<p>certification period of 10/1/13 - 11/29/13 which had been signed by the physician on 11/13/13. The plan of care identified the skilled nurse is to provide 2 visits a week X 6 weeks and 1 visit x 4 weeks and 4 as needed visits for symptom management. No visits occurred week 8 between 11/17/13 - 11/23/13.</p> <p>6. Clinical record #20, SOC 11/6/13 and a primary diagnosis of orthostatic hypertension, included a plan of care for the certification period of 11/6/13 - 1/4/13. This record failed to evidence Employee D, LPN, completed the medication regime as ordered on the plan of care at a visit on 11/12/13. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 11/6/13 - 1/4/13 included an order to establish and instruct in med regime actions and side effects and instruction for the LPN to follow all MD orders including to ensure the patient has a complete list of medications and understands the purpose and side effects of all medications. This document was completed on 10/28/13 and signed by Employee I, RN.</p> <p>a. A clinical visit note dated 11/12/13 and completed by Employee D, LPN, failed to show that the LPN had instructed in med regime actions or looked at the list</p>						

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	<p>of medications and completed teaching over the patient's medications.</p> <p>b. On 12/6/13 at 3:30 PM, Employee B, RN, indicated the plan of care was not followed for patient #20 at the visit on 11/12/13.</p> <p>7. The agency policy titled "Medical Supervision" with an approved date of 10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members. a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."</p> <p>8. The agency policy titled "Skilled Nursing Service" with a policy date of 6/12/12 stated, "Skilled nursing services are provided under the supervision of a registered nurse and in accordance with physician's orders and the patient's plan of care."</p>				

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G000159	<p>484.18(a) PLAN OF CARE 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 home visit observation, policy review, clinical record review, and staff and patient interview, the agency failed to ensure the plan of care was signed by the physician in a timely manner and contained the medical equipment used by / for the patient for 5 of 20 records reviewed (#3, #11, #16, #18, #19) with the potential to affect all the 823 active patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, Start of Care (SOC) 10/9/12, included a plan of care for the certification period of 12/3/13 - 1/31/14, that failed to evidence all the medical equipment used by the patient. The plan of care failed to evidence the patient used a compression pump.</p> <p>a. At a home visit on 12/9/13 at 11:25</p>	G000159	<p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Plan of Care – Timely physician signature Both of the client’s plan of care were signed at the time of survey. Plan of Care – Medical Equipment If the affected clients are recertified, all plan of care locators will be completed. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Plan of Care – Timely physician signature Compiled the list of plans of care that are greater than 30 days old. In a random sampling of outstanding POC there have been many attempts to get the POC returned signed. Health Information Management Coordinator is calling each physician to discuss with the practice manager how we can facilitate the return of the</p>	01/17/2014	

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	<p>AM, patient #3's equipment was observed to include a compression pump for the bilateral legs.</p> <p>b. At a home visit interview on 12/9/13 at 11:25 AM, Employee K, physical therapist and patient #3 indicated the compression pump was used on the patient's legs 1 hour daily.</p> <p>2. Clinical record #11, SOC 10/22/13, included a plan of care for the certification period of 10/22/13 - 12/20/13, that failed to evidence all the medical equipment used by the patient. The plan of care failed to evidence the patient used a CPAP machine.</p> <p>a. On 12/11/13 at 10:10 AM, patient #11 indicated being on a CPAP or sleep apnea machine at night for years.</p> <p>b. On 12/12/13 at 12:30 PM, Employee BB, RN, indicated the CPAP machine was not on the plan of care.</p> <p>3. Clinical record #16, SOC 9/26/13,, included a plan of care for the certification period for 11/25/13 - 1/23/13 that failed to evidence all the medical equipment used by the patient. A clinical document titled "11/21/2013 SN [skilled nurse] Recertification" with a date of 11/21/13 and completed by Employee</p>		<p>signed POC. Plan of Care – Medical EquipmentCorrection plan establishedDescribe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Plan of Care – Timely physician signatureEducate RNs & PTs on SOC/Recert Timeframe ExpectationsEducate Coders on SOC/Recert Timeframe ExpectationsEducate HIM staff responsible for physician orders on the Timeframe Expectations All education to be completed by 1/17/2014Plan of Care – Medical EquipmentConsulted the information technology system analyst to identify if items that fall under the “Plan of Care (POC/485)” and the “Discharge Plans (POC/485)” tabs within the electronic medical record could be made “hard stops” requiring an answer. Staff will be reeducated on all items that are required to be part of the 485. DME completion added to our admission and recert checklist. Information technology system analyst will add two options to the DME list: “none” which means patient does not have any supplies in the home and “other” which will allow the clinician to free-type text. Clinical record review updated to include DME Describe how the corrective action(s) will be monitored to</p>				

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	<p>DD, RN, stated, "Tracheostomy Shiley size 7.5."</p> <p>a. A clinical document titled "Home Health Certification and plan of care" with a date of 11/25/13 and physician signature of 12/5/13 failed to evidence the patient's tracheostomy equipment was listed under DME and supplies.</p> <p>b. On 12/11/13 at 4:35 PM, Employee B, RN, indicated the tracheostomy equipment for patient was not listed on the plan of care.</p> <p>4. Clinical record #18, SOC 6/21/13, included a plan of care for the certification period of 6/21/13 - 8/19/13, which had been signed by the physician until 10/29/13.</p> <p>On 12/10/13 at 4:10 PM, Employee B, RN, indicated the plan of care was signed on 10/29/13, and this was not a timely signature.</p> <p>5. Clinical record #19, SOC 10/1/13, included a plan of care for the certification period of 10/1/13 - 11/29/13 which was not signed by the physician until 11/13/13. The patient was on a mechanical soft diet with honey thickened liquids which was not listed on the plan of care.</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Plan of Care – Timely physician signatureThe executive director of quality and risk management and the homecare director are responsible for the audits.The systems to be used for monitoring are the electronic medical record and benchmarking software.February & March 2014 - Weekly 5% audit of all Start of Care and Recertification OASIS completed to monitor clinician, QR and HIM timeliness.Weekly 5% audit of Plans of Care submitted 1/20 or later for timely return of signed POCMonthly Ongoing - 5% audit of all Start of Care and Recertification OASIS completed to monitor clinician, QR and HIM timeliness.5% audit of Plans of Care submitted 1/20 or later for timely return of signed POC. Plan of Care – Medical EquipmentWeekly monitoring by the clinical managers of the report created by information technology system analyst that flags blank DME or "NA" DME on the plan of careRecord reviews to be completed monthly by clinical managers to ensure DME on plan of care</p>				

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	<p>a. A clinical document titled "Home Health Certification and plan of care" with a date of 9/30/13 and physician signature of 11/13/13 failed to include the patient's mechanical soft diet and honey thickened liquids order.</p> <p>b. A 10/8/13 speech evaluation clinical note from Employee CC, speech therapist, evidenced the patient had a mechanical soft diet and honey thickened liquids.</p> <p>c. On 12/10/13 at 1:15 PM, Employee B, RN, indicated the physician had not signed the plan of care in a timely manner and that mechanical soft diet and honey thickened liquids were not on the plan of care.</p> <p>6. The agency policy titled "Medical Supervision" with an approved date of 10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members. a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... The patient's plan of care is</p>						

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	signed by the physician and dated. Changes in the patient's plan of care are written, counter - signed by the physician within 30 days or as applicable, and incorporated into the medical record. If the visit frequency is less than the physician's orders, the plan of care has been altered and the physician must be notified ... The patient's plan of care includes but is not limited to the following ... functional limitations and activities permitted, medication profile, needed equipment and medical supplies ... frequency and duration of services delivered ... nutritional needs or diet ... treatments and / or services to be provided by each discipline ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."				

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on home visit observation, clinical record and agency policy review, and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 4 of 20 records reviewed (1, 6, 19, 20) creating the potential to affect all the agency's current patients with skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 11/21/13 and diagnosis of pressure ulcer stage III, included a plan of care for the certification period of 11/21/13 - 1/19/14 which included orders to perform a general assessment and monitor and instruct in process and management of disease and all co-morbidities, signs and symptoms to report to MD, and to assess the patient for skin breakdown. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot and assess the right foot. The nurse did not assess the left foot or monitor the left foot for skin breakdown.</p> <p>2. Clinical record #6, SOC 3/31/13 and a</p>	G000170	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Discussion with each clinician involved to make sure that policy and procedure is understood. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Reviewed policies "Medical Supervision" and "Skilled Nursing Service" Reviewed LPN job description and scope of practice Correction plan established Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Planned education of clinicians for care planning, physician orders and visit schedules the week of Jan 13th, 2014 Record review tool revised to include compliance with plan of care Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Record reviews to be	01/17/2014			

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	<p>diagnosis of non-healing surgical wound and morbid obesity, included a plan of care for the certification period of 11/26/13 - 1/24/13, with orders to perform a general assessment and to monitor and instruct in process and management of disease and co-morbidities and goals for the skilled nurse to assess palpable peripheral pulses. At a home visit on 12/9/13 at 3:10 PM, Employee E, Registered Nurse (RN), was observed to assess the patient's legs and noted edema around the cuffs of the patient's socks. She did not take the socks off and look at the feet or palpate the pedal pulses in the patient's feet.</p> <p>3. On 12/10/13 at 11:10 AM, Employee B, RN, indicated the feet were not assessed at the home visits noted for Clinical record #1 and Clinical record #6 in findings #1 and #2.</p> <p>4. Clinical record #19, SOC 10/1/13, included a plan of care for the certification period of 10/1/13 - 11/29/13 which had been signed by the physician on 11/13/13. The plan of care identified the skilled nurse is to provide 2 visits a week X 6 weeks and 1 visit x 4 weeks and 4 as needed visits for symptom management. No visits occurred week 8 between 11/17/13 - 11/23/13.</p>		<p>completed monthly by clinical managers Health information management auditors complete routine audits that include compliance with ordered level of careData analyzed to determine patterns/need for further corrective action.5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with ordered plan of care.Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration.</p>				

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	<p>5. Clinical record #20, SOC 11/6/13 and a primary diagnosis of orthostatic hypertension, included a plan of care for the certification period of 11/6/13 - 1/4/13. This record failed to evidence Employee D, LPN, completed the medication regime as ordered on the plan of care at a visit on 11/12/13. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 11/6/13 - 1/4/13 included an order to establish and instruct in med regime actions and side effects and instruction for the LPN to follow all MD orders including to ensure the patient has a complete list of medications and understands the purpose and side effects of all medications. This document was completed on 10/28/13 and signed by Employee I, RN.</p> <p>a. A clinical visit note dated 11/12/13 and completed by Employee D, LPN, failed to show that the LPN had instructed in med regime actions or looked at the list of medications and completed teaching over the patient's medications.</p> <p>b. On 12/6/13 at 3:30 PM, Employee B, RN, indicated the plan of care was not followed for patient #20 at the visit on 11/12/13.</p> <p>6. The agency policy titled "Medical</p>			

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	<p>Supervision" with an approved date of 10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members.</p> <p>a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."</p> <p>7. The agency policy titled "Skilled Nursing Service" with a policy date of 6/12/12 stated, "Skilled nursing services are provided under the supervision of a registered nurse and in accordance with physician's orders and the patient's plan of care."</p>			

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G000229	<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.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were conducted every 14 days for 2 of 20 (#7, #8) clinical records reviewed of patients receiving HHA and Skilled Nursing (SN) services with the potential to affect all the agency's patients receiving skilled nursing and home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #7, start of care 11-18-12, contained a plan of care for the certification period 11-8-13 to 1-6-14 with orders for HHA for to visit 5 times weekly for 9 weeks and the SN to visit 3 times weekly for 10 weeks with 12 PRN (as needed) visits for catheter issues. A HHA supervisory visits should have been conducted by 11-22-13 but was not conducted until 11-29-13. 2. Clinical record #8, start of care 10-24-13, contained a plan of care for the certification period 11-24-13 to 12-22-13. 	G000229	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Education provided to each staff member identified to ensure understanding of the standard. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Met with clinical managers on 1/2/2014 and reviewed the citation/deficiency, current practice, electronic medical record process and formulated a corrective action plan. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Education provided to all clinical staff related to the regulations surrounding home health aide services and supervision by 1/17/2014. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	01/17/2014			

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	<p>The patient discharged to the hospital and returned to home health with a ROC (resumption of care) assessment 11-8-13. The POC (plan of care) beginning 11-8-13 included orders for the skilled nurse to visit 1 time week 1, 3 times for 2 weeks, 2 times for 3 weeks, 1 time for 4 weeks and 4 PRN (as needed) for symptom management. The home health aide was to visit 2 times weekly for 10 weeks. The record failed to evidence a supervisory visit was completed by 11-26-13.</p> <p>After review of the record #8 with Employee BB on 12-12-13 at 10:30 AM, Employee BB agreed that a HHA supervisory visit was due by 11-26-13 and was either not done or not documented.</p> <p>3. On 12-12-13 at 10:10 AM, employee BB indicated supervisory visits were not done and/or not documented according to agency practice for patient #7 and #8 and no further documentation was available related to supervisory visits for these patients. Employee BB agreed the agency did not perform supervisory visits for patient #7 and #8 according to agency policy.</p> <p>4. Review of policy "HHA 1 Home Health Services and Supervision", dated</p>		<p>put into place. Medical record review is 5% of all discharged charts quarterly. Auditing for home health aide supervisory visits every 2 weeks has been added to the audit tool. Clinical managers will perform the audits throughout the year. Concurrent auditing by Health Information Management auditors will take place monthly covering 10% of the active patients that month with a home health aide assigned.</p>		

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	6-12-12, indicated supervisory visits for HHA services are performed "as indicated by regulatory agencies."				

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G000236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure summary reports were completed and copies placed in the record for 1 of 20 records reviewed with the potential to affect all patients (#4)</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Clinical record #4, start of care (SOC), failed to evidence the 60 day summary had been completed for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13. 2. On 12/12/13 at 12:05 PM, Employee BB, Registered Nurse, indicated there was no summary in the record. 	G000236	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Records reviewed. The computer system needs updated to include needed patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The computer system needs updated to include patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should	01/17/2014	

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			include any system changes you made. Review Epic system for updates needed – by 1/3/14Create Tips & Tricks for 60 Day Summary by 1/10/14Educate Clinicians on 60 Day Summary process by 1/17/14Educate HIM Auditors and Coders on the need to audit for 60 day summaries by 1/17/14Update HIM Auditor and Coders audit tool/process to include 60 day summaries by 1/17/14Create the process for sending the physician the 60 Day summary by 1/17/14Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The executive director of quality and risk management and the home care director are responsible for the audits/record reviews.The systems to be used for monitoring are the electronic medical record and benchmarking systems. February & March 2014 - Weekly 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance. Monthly Ongoing - 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance.		

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N000000	<p>This visit was for a home health state licensure survey.</p> <p>Survey dates: 12/5/13 - 12/12/13</p> <p>Facility #: IN005265</p> <p>Medicaid #: 100272620A</p> <p>Surveyors: Ingrid Miller, RN, PHNS Janet Brandt, RN, PHNS</p> <p>Census service type: 6077 skilled unduplicated patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 19, 2013</p>	N000000		

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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on home visit observation, policy and procedure review, and interview, the agency failed to ensure employees (Employees I, K, D) followed agency policies and procedures related to infection control at 3 of 10 home visit observations (patient #1, 3, and 12) resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>1. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot by using an antiseptic gel to cleanse her hands and then attempted to don gloves. One glove fell on the floor. Employee I picked up the glove off the floor and donned it and the other glove. She then removed the patient's dressing and did not remove the dirty gloves. She readied her supplies by placing the scissors, the Aquacel Ag rope treatment package, and kerlix gauze on the floor. She then dressed the wound</p>	N000470	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Policies and procedures reviewed and revisions made. Provided education to staff involved in the cited visits. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Policies and procedures reviewed and revisions made. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Policy and procedure review indicated need to revise infection prevention policy and the Preparation of Work Area procedure. Education planned for all clinical staff to reeducate on policy/procedures indicated for infection prevention by 1/17/14 Revision of field supervisory form to include infection prevention measures Describe how the	01/17/2014	

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	<p>with these supplies.</p> <p>On 12/10/13 at 10:45 AM, Employee B, Registered Nurse, indicated visits observed with patient #1 failed to evidence infection prevention.</p> <p>2. On 12/9/13 at 11:05 AM, Employee K, physical therapist, was observed to change a compression dressing on patient #3's left leg and foot. This patient had a diagnosis of lymphedema in the lower extremities. (The other dressing was changed by skilled nursing due to a wound on the right leg.) She placed her computer and dressing supplies including kerlix and a protective wound ointment in a plastic tube on the floor. She removed the dressing from the patient's left leg and washed her hands and then applied the protective barrier ointment with ungloved hands. The patient's skin was dry and intact. She then proceeded to dress the patient's leg with the dressing supplies which had been placed on the floor.</p> <p>On 12/10/13 at 10:45 AM, Employee B, Registered Nurse, indicated visits observed with patient #3 failed to evidence infection prevention.</p> <p>3. On 12/9/13 at 11:05 AM, Employee D, LPN, was observed to care for patient #12, a patient with bilateral wounds</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with infection prevention measures. Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration</p>				

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	<p>around the axilla or armpits by applying a wound vac dressing under the right armpit. Patient #12 had visible blood on the skin after the wound care on the right arm pit was completed. The blood was visible on the right chest area, the right arm, and the right axillary area.</p> <p>Employee D touched the dressing with her bare hands on the dressing area. The wound dressing was clean and did not have visible blood on it. However, the skin around this area still had blood visible and had the potential to come in contact with the dressing under the right arm.</p> <p>On 12/9/13 at 12 noon, Employee W, RN, indicated blood was visible on the skin around the dressing area.</p> <p>4. The agency policy titled "Infection Prevention" with a review date of 3/8/13 stated, "Purpose: To protect individuals from transmission of communicable / infectious diseases ... infection: the transmission of a pathogenic microorganism to a host ... Modes of transmission in home care: indirectly on the healthcare personnel hands or contaminated equipment are some of the ways the infection can be spread ... Standard Precautions : Should be used during the care of patients whether or not the person is known to be infectious.</p>				

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	<p>Standard precautions are designed to reduce the risk of transmission from both recognized and unrecognized sources of infection. Standard precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions ... may contain transmissible infectious agents ... Clinical bag ... If you use a shoulder bag, you should select a flat hard surface to place the bag and set up work area. Use discretion and consideration when placing bag on patient's furniture ... CHH [Community Home Health] based on CDC guidelines ... b. If hands are not visibly soiled, use an alcohol - based hand rub for routinely decontaminating hands in all other clinical situations described in items C - J. Alternatively, wash hands with antimicrobial soap and water in all clinical situations described in items C - J ... C. decontaminate hands before having direct contact with patients ... decontaminate hands after removing gloves."</p> <p>5. The agency policy titled "Preparation of work area" with a date of 10/11 stated, "To prevent contamination of bag and equipment, avoid cross contamination, and establish a clean work area. Considerations ... as homes differ greatly, clinical staff will need to use judgement</p>			

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	in selecting an appropriate work area ... Procedure: 1. Adhere to standard precautions. Select a flat surface to place bag and set up work area. Use discretion and consideration when placing bag on patient's furniture. Never place bag on floor ... Wash hands ... remove needed items from bag and place on clean surface or paper towel."			

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, agency policy review, home visit observation, and interview, the agency failed to ensure visits and treatments had been provided in accordance with physician orders in 5 of 20 records reviewed (1, 6, 16, 19, 20) creating the potential to affect all the agency's current 823 patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 11/21/13 and diagnosis of pressure ulcer stage III, included a plan of care for the certification period of 11/21/13 - 1/19/14 which included orders to perform a general assessment and monitor and instruct in process and management of disease and all co-morbidities, signs and symptoms to report to MD, and to assess the patient for skin breakdown. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot and assess the right foot. The nurse did not assess the left foot or monitor the left foot for skin breakdown.</p>	N000522	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Discussion with each clinician involved to make sure that policy and procedure is understood. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Reviewed policies "Medical Supervision" and "Skilled Nursing Service" Reviewed LPN job description and scope of practice Correction plan established Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Planned education of clinicians for care planning, physician orders and visit schedules the week of Jan 13th, 2014 Record review tool revised to include compliance with plan of care Describe how the corrective action(s) will be monitored to ensure the deficient practice will	01/17/2014			

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	<p>2. Clinical record #6, SOC 3/31/13 and a diagnosis of non-healing surgical wound and morbid obesity, included a plan of care for the certification period of 11/26/13 - 1/24/13, with orders to perform a general assessment and to monitor and instruct in process and management of disease and co-morbidities and goals for the skilled nurse to assess palpable peripheral pulses. At a home visit on 12/9/13 at 3:10 PM, Employee E, Registered Nurse (RN), was observed to assess the patient's legs and noted edema around the cuffs of the patient's socks. She did not take the socks off and look at the feet or palpate the pedal pulses in the patient's feet.</p> <p>3. On 12/10/13 at 11:10 AM, Employee B, RN, indicated the feet were not assessed at the home visits noted for Clinical record #1 and Clinical record #6 in findings #1 and #2.</p> <p>4. Clinical record #16, SOC 9/26/13, included a plan of care for the certification period of 11/25/13 - 1/23/14. The plan of care failed to evidence orders for the physical therapist visits that were completed on 12/2/13 and 12/5/13.</p> <p>5. Clinical record #19, SOC 10/1/13, included a plan of care for the</p>		not recur, i.e., what quality assurance program will be put into place. Record reviews to be completed monthly by clinical managers Health information management auditors complete routine audits that include compliance with ordered level of care Data analyzed to determine patterns/need for further corrective action. 5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with ordered plan of care. Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration.				

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	<p>certification period of 10/1/13 - 11/29/13 which had been signed by the physician on 11/13/13. The plan of care identified the skilled nurse is to provide 2 visits a week X 6 weeks and 1 visit x 4 weeks and 4 as needed visits for symptom management. No visits occurred week 8 between 11/17/13 - 11/23/13.</p> <p>6. Clinical record #20, SOC 11/6/13 and a primary diagnosis of orthostatic hypertension, included a plan of care for the certification period of 11/6/13 - 1/4/13. This record failed to evidence Employee D, LPN, completed the medication regime as ordered on the plan of care at a visit on 11/12/13. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 11/6/13 - 1/4/13 included an order to establish and instruct in med regime actions and side effects and instruction for the LPN to follow all MD orders including to ensure the patient has a complete list of medications and understands the purpose and side effects of all medications. This document was completed on 10/28/13 and signed by Employee I, RN.</p> <p>a. A clinical visit note dated 11/12/13 and completed by Employee D, LPN, failed to show that the LPN had instructed in med regime actions or looked at the list</p>			

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	<p>of medications and completed teaching over the patient's medications.</p> <p>b. On 12/6/13 at 3:30 PM, Employee B, RN, indicated the plan of care was not followed for patient #20 at the visit on 11/12/13.</p> <p>7. The agency policy titled "Medical Supervision" with an approved date of 10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members. a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."</p> <p>8. The agency policy titled "Skilled Nursing Service" with a policy date of 6/12/12 stated, "Skilled nursing services are provided under the supervision of a registered nurse and in accordance with physician's orders and the patient's plan of care."</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 home visit observation, policy review, clinical record review, and staff and patient interview, the agency failed to ensure the plan of care was signed by the physician in a timely manner and contained the medical equipment used by / for the patient for 5 of 20 records reviewed (#3, #11, #16, #18, #19) with the potential to affect all the 823 active patients of the agency.</p>	N000524	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Plan of Care – Timely physician signatureBoth of the client’s plan of care were signed at the time of survey. Plan of Care – Medical EquipmentIf the affected clients are recertified, all plan of care locators will be completed. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the	01/17/2014			

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	<p>Findings</p> <p>1. Clinical record #3, Start of Care (SOC) 10/9/12, included a plan of care for the certification period of 12/3/13 - 1/31/14, that failed to evidence all the medical equipment used by the patient. The plan of care failed to evidence the patient used a compression pump.</p> <p>a. At a home visit on 12/9/13 at 11:25 AM, patient #3's equipment was observed to include a compression pump for the bilateral legs.</p> <p>b. At a home visit interview on 12/9/13 at 11:25 AM, Employee K, physical therapist and patient #3 indicated the compression pump was used on the patient's legs 1 hour daily.</p> <p>2. Clinical record #11, SOC 10/22/13, included a plan of care for the certification period of 10/22/13 - 12/20/13, that failed to evidence all the medical equipment used by the patient. The plan of care failed to evidence the patient used a CPAP machine.</p> <p>a. On 12/11/13 at 10:10 AM, patient #11 indicated being on a CPAP or sleep apnea machine at night for years.</p> <p>b. On 12/12/13 at 12:30 PM,</p>		<p>deficient practice for any client the facility identified as being affected. Plan of Care – Timely physician signatureCompiled the list of plans of care that are greater than 30 days old.In a random sampling of outstanding POC there have been many attempts to get the POC returned signed.Health Information Management Coordinator is calling each physician to discuss with the practice manager how we can facilitate the return of the signed POC. Plan of Care – Medical EquipmentCorrection plan establishedDescribe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Plan of Care – Timely physician signatureEducate RNs & PTs on SOC/Recert Timeframe ExpectationsEducate Coders on SOC/Recert Timeframe ExpectationsEducate HIM staff responsible for physician orders on the Timeframe Expectations All education to be completed by 1/17/2014Plan of Care – Medical EquipmentConsulted the information technology system analyst to identify if items that fall under the “Plan of Care (POC/485)” and the “Discharge Plans (POC/485)” tabs within the electronic medical record could be made “hard stops” requiring an answer. Staff will be</p>		

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	<p>Employee BB, RN, indicated the CPAP machine was not on the plan of care.</p> <p>3. Clinical record #16, SOC 9/26/13,, included a plan of care for the certification period for 11/25/13 - 1/23/13 that failed to evidence all the medical equipment used by the patient. A clinical document titled "11/21/2013 SN [skilled nurse] Recertification" with a date of 11/21/13 and completed by Employee DD, RN, stated, "Tracheostomy Shiley size 7.5."</p> <p>a. A clinical document titled "Home Health Certification and plan of care" with a date of 11/25/13 and physician signature of 12/5/13 failed to evidence the patient's tracheostomy equipment was listed under DME and supplies.</p> <p>b. On 12/11/13 at 4:35 PM, Employee B, RN, indicated the tracheostomy equipment for patient was not listed on the plan of care.</p> <p>4. Clinical record #18, SOC 6/21/13, included a plan of care for the certification period of 6/21/13 - 8/19/13, which had been signed by the physician until 10/29/13.</p> <p>On 12/10/13 at 4:10 PM, Employee B, RN, indicated the plan of care was signed</p>		<p>reeducated on all items that are required to be part of the 485. DME completion added to our admission and recert checklist. Information technology system analyst will add two options to the DME list: "none" which means patient does not have any supplies in the home and "other" which will allow the clinician to free-type text. Clinical record review updated to include DME Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Plan of Care – Timely physician signatureThe executive director of quality and risk management and the homecare director are responsible for the audits.The systems to be used for monitoring are the electronic medical record and benchmarking software. February & March 2014 - Weekly 5% audit of all Start of Care and Recertification OASIS completed to monitor clinician, QR and HIM timeliness.Weekly 5% audit of Plans of Care submitted 1/20 or later for timely return of signed POCMonthly Ongoing - 5% audit of all Start of Care and Recertification OASIS completed to monitor clinician, QR and HIM timeliness.5% audit of Plans of Care submitted 1/20 or later for timely return of signed POC. Plan of Care – Medical EquipmentWeekly monitoring by</p>		

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	<p>on 10/29/13, and this was not a timely signature.</p> <p>5. Clinical record #19, SOC 10/1/13, included a plan of care for the certification period of 10/1/13 - 11/29/13 which was not signed by the physician until 11/13/13. The patient was on a mechanical soft diet with honey thickened liquids which was not listed on the plan of care.</p> <p>a. A clinical document titled "Home Health Certification and plan of care" with a date of 9/30/13 and physician signature of 11/13/13 failed to include the patient's mechanical soft diet and honey thickened liquids order.</p> <p>b. A 10/8/13 speech evaluation clinical note from Employee CC, speech therapist, evidenced the patient had a mechanical soft diet and honey thickened liquids.</p> <p>c. On 12/10/13 at 1:15 PM, Employee B, RN, indicated the physician had not signed the plan of care in a timely manner and that mechanical soft diet and honey thickened liquids were not on the plan of care.</p> <p>6. The agency policy titled "Medical Supervision" with an approved date of</p>		<p>the clinical managers of the report created by information technology system analyst that flags blank DME or "NA" DME on the plan of careRecord reviews to be completed monthly by clinical managers to ensure DME on plan of care</p>		

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	<p>10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members.</p> <p>a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... The patient's plan of care is signed by the physician and dated. Changes in the patient's plan of care are written, counter - signed by the physician within 30 days or as applicable, and incorporated into the medical record. If the visit frequency is less than the physician's orders, the plan of care has been altered and the physician must be notified ... The patient's plan of care includes but is not limited to the following ... functional limitations and activities permitted, medication profile, needed equipment and medical supplies ... frequency and duration of services delivered ... nutritional needs or diet ... treatments and / or services to be provided by each discipline ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."</p>			

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N000529	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record review, policy review, and interview, the agency failed to ensure a written summary was completed and sent to the physician every 60 days for 3 of 20 records reviewed (#3, 4, 16) with the potential to affect all the agency patients receiving services longer than 60 days.</p> <p>Findings</p> <p>Concerning no 60 day summary in the records</p> <p>1. Clinical record #4, start of care (SOC), failed to evidence the 60 day summary had been completed for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>On 12/12/13 at 12:05 PM, Employee BB, Registered Nurse, indicated there was no summary in the record.</p> <p>Concerning no 60 day summary sent to</p>	N000529	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Records reviewed. The computer system needs updated to include needed patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The computer system needs updated to include patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Review Epic system for updates needed – by 1/3/14 Create Tips & Tricks for 60	01/17/2014	

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	<p>the physician</p> <p>2. Clinical record #3, SOC failed to evidence the 60 day summary had been sent to the physician for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>3. Clinical record #16, SOC failed to evidence the 60 day summary had been sent to the physician for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p> <p>4. On 12/12/13 at 12:25 PM, Employee BB indicated the summaries for clinical record #3 and #16 had not been sent to the attending physicians.</p> <p>5. The agency policy titled "Patient Progress / Summary Report" with an effective date of 4/2/12 stated, "A progress report is communicated to the physician at least every 60 days or more frequently if warranted ... the clinical findings will serve as the patient's progress summary."</p>		<p>Day Summary by 1/10/14Educate Clinicians on 60 Day Summary process by 1/17/14Educate HIM Auditors and Coders on the need to audit for 60 day summaries by 1/17/14Update HIM Auditor and Coders audit tool/process to include 60 day summaries by 1/17/14Create the process for sending the physician the 60 Day summary by 1/17/14Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The executive director of quality and risk management and the home care director are responsible for the audits/record reviews. The systems to be used for monitoring are the electronic medical record and benchmarking systems. February & March 2014 - Weekly 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance. Monthly Ongoing - 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance.</p>		

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on home visit observation, clinical record and agency policy review, and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 4 of 20 records reviewed (1, 6, 19, 20) creating the potential to affect all the agency's current patients with skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 11/21/13 and diagnosis of pressure ulcer stage III, included a plan of care for the certification period of 11/21/13 - 1/19/14 which included orders to perform a general assessment and monitor and instruct in process and management of disease and all co-morbidities, signs and symptoms to report to MD, and to assess the patient for skin breakdown. On 12/6/13 at 10:30 AM, Employee I, Licensed Practical Nurse (LPN), was observed to complete a wound dressing on patient #1's right foot and assess the right foot. The nurse did not assess the left foot or monitor the left foot for skin</p>	N000537	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Discussion with each clinician involved to make sure that policy and procedure is understood. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Reviewed policies "Medical Supervision" and "Skilled Nursing Service" Reviewed LPN job description and scope of practice Correction plan established Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Planned education of clinicians for care planning, physician orders and visit schedules the week of Jan 13th, 2014 Record review tool revised to include compliance with plan of care Describe how the corrective action(s) will be monitored to ensure the deficient practice will	01/17/2014			

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	<p>breakdown.</p> <p>2. Clinical record #6, SOC 3/31/13 and a diagnosis of non-healing surgical wound and morbid obesity, included a plan of care for the certification period of 11/26/13 - 1/24/13, with orders to perform a general assessment and to monitor and instruct in process and management of disease and co-morbidities and goals for the skilled nurse to assess palpable peripheral pulses. At a home visit on 12/9/13 at 3:10 PM, Employee E, Registered Nurse (RN), was observed to assess the patient's legs and noted edema around the cuffs of the patient's socks. She did not take the socks off and look at the feet or palpate the pedal pulses in the patient's feet.</p> <p>3. On 12/10/13 at 11:10 AM, Employee B, RN, indicated the feet were not assessed at the home visits noted for Clinical record #1 and Clinical record #6 in findings #1 and #2.</p> <p>4. Clinical record #19, SOC 10/1/13, included a plan of care for the certification period of 10/1/13 - 11/29/13 which had been signed by the physician on 11/13/13. The plan of care identified the skilled nurse is to provide 2 visits a week X 6 weeks and 1 visit x 4 weeks and 4 as needed visits for symptom</p>		<p>not recur, i.e., what quality assurance program will be put into place. Record reviews to be completed monthly by clinical managers Health information management auditors complete routine audits that include compliance with ordered level of care Data analyzed to determine patterns/need for further corrective action. 5-10 random supervisory visits per month conducted by clinical managers, homecare director, specialized RN coordinators, and/or administration to ensure compliance with ordered plan of care. Supervisory visits out of compliance will be reviewed and followed up with employee by a member of administration.</p>		

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	<p>management. No visits occurred week 8 between 11/17/13 - 11/23/13.</p> <p>5. Clinical record #20, SOC 11/6/13 and a primary diagnosis of orthostatic hypertension, included a plan of care for the certification period of 11/6/13 - 1/4/13. This record failed to evidence Employee D, LPN, completed the medication regime as ordered on the plan of care at a visit on 11/12/13. A clinical document titled "Home Health Certification and Plan of Care" for the certification period of 11/6/13 - 1/4/13 included an order to establish and instruct in med regime actions and side effects and instruction for the LPN to follow all MD orders including to ensure the patient has a complete list of medications and understands the purpose and side effects of all medications. This document was completed on 10/28/13 and signed by Employee I, RN.</p> <p>a. A clinical visit note dated 11/12/13 and completed by Employee D, LPN, failed to show that the LPN had instructed in med regime actions or looked at the list of medications and completed teaching over the patient's medications.</p> <p>b. On 12/6/13 at 3:30 PM, Employee B, RN, indicated the plan of care was not followed for patient #20 at the visit on</p>						

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	<p>11/12/13.</p> <p>6. The agency policy titled "Medical Supervision" with an approved date of 10/29/06 and review date of 10/25/12 stated, "An individualized plan of care is developed and ordered by the physician in consultation with the patient and or parent / guardian, the home health care staff and interdisciplinary team members. a. Home health care staff members accept a patient and administer his / her care and treatment according to the plan of care ordered by the patient's attending physician ... Orders for therapy services include specific procedures and modalities to be used and the amount, frequency and duration of services."</p> <p>7. The agency policy titled "Skilled Nursing Service" with a policy date of 6/12/12 stated, "Skilled nursing services are provided under the supervision of a registered nurse and in accordance with physician's orders and the patient's plan of care."</p>				

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure summary reports were completed and copies placed in the record for 1 of 20 records reviewed with the potential to affect all patients (#4)</p> <p>Findings Include:</p> <p>1. Clinical record #4, start of care (SOC), failed to evidence the 60 day summary had been completed for the certification periods of 9/1/13 - 10/30/13 and 10/31/13 - 12/29/13.</p>	N000608	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Records reviewed. The computer system needs updated to include needed patient and physician text and a contact type for the 60 day summaries. We are working with the systems analysts to get the system updated. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The computer system needs updated to include patient and physician text and a contact type for the 60	01/17/2014			

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	2. On 12/12/13 at 12:05 PM, Employee BB, Registered Nurse, indicated there was no summary in the record.		day summaries. We are working with the systems analysts to get the system updated. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Review Epic system for updates needed – by 1/3/14 Create Tips & Tricks for 60 Day Summary by 1/10/14 Educate Clinicians on 60 Day Summary process by 1/17/14 Educate HIM Auditors and Coders on the need to audit for 60 day summaries by 1/17/14 Update HIM Auditor and Coders audit tool/process to include 60 day summaries by 1/17/14 Create the process for sending the physician the 60 Day summary by 1/17/14 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The executive director of quality and risk management and the homecare director are responsible for the audits/record reviews. The systems to be used for monitoring are the electronic medical record and benchmarking systems. February & March 2014 - Weekly 5% audit of all Recertification OASIS completed to monitor for 60 day summary compliance. Monthly Ongoing - 5% audit of all Recertification OASIS completed		

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