STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157613	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING HANDS R ON THE WAY LLC	3523 165TH STREET HAMMOND, IN 46323

(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
G000000	This visit was a home health federal recertification survey. The survey was partial extended. Date of survey: 4-2-13, 4-3-13, and 4-4-13. Facility #: IN0011809. Medicaid Vendor #: 200957810. Surveyor: Janet Brandt, RN, PHNS Number of skilled unduplicated admissions: 43. Census: 5. Home Vistis: 3. Quality Review: Joyce Elder, MSN, BSN, RN April 8, 2013	G000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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G000158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on interview and review of clinical records, the agency failed to ensure skilled nursing and home health aide visits had been provided as ordered on the plan of care in 3 (#3, #4, and #7) of 8 records reviewed creating the potential to affect all of the agency's current patients receiving skilled nursing (SN) and/or home health aide (HHA) services. Findings include: 1. Clinical record #3 included a plan of care for the certification period 3-20-13 to 5-18-13 with orders for HHA 3 times weekly for 9 weeks. The record evidenced 1 missed HHA visit the first week of the certification period 3-20-13 to 3-23-13. 2. Clinical record #4 included a plan of care for the certification period 3/28/13-5/26/13 with orders for SN 2 times weekly for 2 weeks and 1 time weekly for 6 weeks. The record evidenced only 1 SN visit for weeks 1	G000158	The Administrator or her designee will educate all staff members on the new policy of phoning in each day the names of the patients to be seen for that particular day, ensuring skilled nursing and home health aide visits are made as ordered on the plan of care and that proper visit frequency will be followed as order. The Office Manager or her designee will review the phone messages daily to ensure patients are visited according to the POC. If any patient is NOT seen by the end of the day, the staff member is to call and report the missed visit. The Director of Nursing or her designee will be notified of any missed visit for follow up. The Director of Nursing or her designee will also educate all nursing staff members on documentation for 'Missed Visits', as well as the importance of informing the patient's physician of the missed visit. Lastly, the Director of Nursing or her designee will educate all staff members on certification and re-certification process. Fifty percent or a minimum of 10 (whichever is greater) of all clinical records will be audited quarterly for evidence that the	05/03/2013

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	(3/28 - 5/26/13) and 2 (3/31-4/6/13). 3. Clinical record #7 included a plan of care for the certification period 2-9-13 to 4-9-13 with orders for the skilled nurse to visit 3 times weekly for 3 weeks, 2 times weekly for 3 weeks, and 1 time weekly for 3 weeks. The HHA was to visit 2 times a week for 9 weeks. During week 5 (3/3/13-3/9/13), 1 SN and 2 HHA visits were missed. During week 6 (3/10/13-3/16/13), 1 SN and 2 HHA visits were missed. 4. On 4-4-13 at 2:00 PM, employee A indicated there was no additional documentation available for record #3, #4, or #7 and the visits had been missed.		visit frequency listed in the plan of care is met. Target threshold for compliance is 95%. This will be tracked by the Performance Improvement Committee. The Director of Nursing or her designee will be responsible for implementing and monitoring these corrective measures to ensure the deficiency is corrected.	

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G000337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review, policy review and staff interview, the agency failed to ensure a drug review was updated as needed for 1 of 8 (#4) records reviewed with the potential to affect all patients in the agency. Findings include: 1. Clinical record #4, Start of Care (SOC) 6-1-12, included an updated comprehensive assessment and "Medication Profile-Continuation Sheet" dated 3-28-13. On 4-1-13, a physician order was received for the addition of Tylenol 650 milligrams by mouth every 6 hours as needed. The "Medication Profile-Continuation Sheet" failed to evidence the Tylenol had been added. 2. On 4-4-13 at 2:30 PM, Employee B indicated there was no other documentation available and agency policy regarding updating the medication	G000337	The Director of Nursing or her designee will educate all nursing staff on 'Medication Profile' policy and 'Medication Profile' Form. Fifty percent or a minimum of 10 (whichever is greater) of all clinical records will be audited quarterly for evidence that the visit frequency listed in the plan of care is met. Target threshold for compliance is 95%. This will be tracked by the Performance Improvement Committee. The Director of Nursing or her designee will be responsible for implementing and monitoring these corrective measures to ensure the deficiency is corrected. This will be tracked by the Performance Improvement Committee.	05/03/2013

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	profile was not followed. Employee B was not aware that the medication profile had to be updated with any new changes in medication. 3. Agency policy "Medication Profile C-700", undated, states, under "Special Instructions" on page #114, under #10, "The Medication Profile shall be reviewed by a Registered Nurse every 60 days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at minimum, every 60 days thereafter."			

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N000000	This was a home health state licensure survey. Date of survey: 4-2-13, 4-3-13, and 4-4-13. Facility #: IN0011809. Medicaid Vendor #: 200957810. Surveyor: Janet Brandt, RN, PHNS Number of skilled unduplicated admissions: 43. Census: 5. Home Vistis: 3. Quality Review: Joyce Elder, MSN, BSN, RN April 8, 2013	N000000		

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N000456	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based interview, policy review, and document review, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency. Findings: 1. On 04/04/13 at 11:00 AM, Employee A indicated a quality improvement program binder was reviewed at the annual Professional Advisory Committee meeting, last held 1-4-13. There had been no development of a program for the agency with measurable goals that would result in overall improvement of the agency services. Employee A indicated the agency was not following its own policies related to a quality improvement program. 2. On 4-4-13 at 11:00 AM, Employee C indicated there was no documentation of a	N000456	The Administrator or Director of Nursing will educate all staff on the 'Performance Improvement' policy by May 3, 2013. The Performance Improvement Committee will meet monthly in order to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolve identified problems and improves patient care provided by the agency. This deficiency will be corrected though performance improvement and will include but not be limited to: chart audits, infection control, staff education/monitoring, patient care. The PDCA (Plan-Do-Check-Act) Model will be utilized after educating all staff. The Director of Nursing or her designee will be responsible for implementing and monitoring these corrective measures to ensure the deficiency is corrected The Administrator or Director of Nursing or their designees will be responsible for all collection, monitoring, educating and	05/03/2013

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	quality assurance program as described in the Policy B-260 at this time but discussion had been initiated about the creation of such a program and, going forward, there would be a program as per policy. 3. The agency policy titled "Performance Improvement B-260", undated, under "Policy," stated, "Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes. This plan will be based on the organization's mission and goals and designed to improve client outcomes and the perceptions of clients/families about the quality and value of services. The agency will adopt a performance improvement model to guide the process." Under Program Objectives the policy states that the agency will "identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation" and "to support the organization's process improvement through data collection and outcome measurement in compliance with OASIS Data Collection required by CMS." 4. Review of agency document titled "Quality Assurance / Improvement Minutes", dated 1-4-13, failed to		reporting of data.	

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	demonstrate any organized plan to measure, assess, and improve the overall performance of the agency as per agency policy.			

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N000472	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based interview, policy review, and document review, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency. Findings: 1. On 04/04/13 at 11:00 AM, Employee A indicated a quality improvement program binder was reviewed at the annual Professional Advisory Committee meeting, last held 1-4-13. There had been no development of a program for the agency with measurable goals that would result in overall improvement of the agency services. Employee A indicated the agency was not following its own policies related to a quality improvement	N000472	The Administrator or Director of Nursing or their designees will be responsible for correcting this deficiency. The Director of Nursing or her designee will educate all staff on the 'Performance Improvement' policy and the PDCA (Plan-Do-Check-Act) Model in order to identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation. The Performance Improvement Committee will meet monthly and will measure, assess and improve the performance of clinical and other processes.	05/03/2013

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	program. 2. On 4-4-13 at 11:00 AM, Employee C indicated there was no documentation of a quality assurance program as described in the Policy B-260 at this time but discussion had been initiated about the creation of such a program and, going forward, there would be a program as per policy. 3. The agency policy titled "Performance Improvement B-260", undated, under "Policy," stated, "Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes. This plan will be based on the organization's mission and goals and designed to improve client outcomes and the perceptions of clients/families about the quality and value of services. The agency will adopt a performance improvement model to guide the process." Under Program Objectives the policy states that the agency will "identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation" and "to support the organization's process improvement through data collection and outcome measurement in compliance with OASIS Data Collection required by CMS."			

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	4. Review of agency document titled "Quality Assurance / Improvement Minutes", dated 1-4-13, failed to demonstrate any organized plan to measure, assess, and improve the overall performance of the agency as per agency policy.			

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N000522	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 interview and review of clinical records, the agency failed to ensure skilled nursing and home health aide visits had been provided as ordered on the plan of care in 3 (#3, #4, and #7) of 8 records reviewed creating the potential to affect all of the agency's current patients receiving skilled nursing (SN) and/or home health aide (HHA) services. Findings include: 1. Clinical record #3 included a plan of care for the certification period 3-20-13 to 5-18-13 with orders for HHA 3 times weekly for 9 weeks. The record evidenced 1 missed HHA visit the first week of the certification period 3-20-13 to 3-23-13. 2. Clinical record #4 included a plan of care for the certification period 3/28/13-5/26/13 with orders for SN 2 times weekly for 2 weeks and 1 time weekly for 6 weeks. The record evidenced only 1 SN visit for weeks 1 (3/28 - 5/26/13) and 2 (3/31-4/6/13).	N000522	The Administrator or her designee will educate all staff members on the new policy of phoning in each day the names of the patients to be seen for that particular day, ensuring skilled nursing and home health aide visits are made as ordered on the plan of care and that proper visit frequency will be followed as order. The Office Manager or her designee will review the phone messages daily to ensure patients are visited according to the POC. If any patient is NOT seen by the end of the day, the staff member is to call and report the missed visit. The Director of Nursing or her designee will be notified of any missed visit for follow up. The Director of Nursing or her designee will also educate all nursing staff members on documentation for 'Missed Visits', as well as the importance of informing the patient's physician of the missed visit. Lastly, the Director of Nursing or her designee will educate all staff members on certification and re-certification process. Fifty percent or a minimum of 10(whichever is greater) of all clinical records will be audited quarterly for evidence that the	05/03/2013

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	3. Clinical record #7 included a plan of care for the certification period 2-9-13 to 4-9-13 with orders for the skilled nurse to visit 3 times weekly for 3 weeks, 2 times weekly for 3 weeks, and 1 time weekly for 3 weeks. The HHA was to visit 2 times a week for 9 weeks. During week 5 (3/3/13-3/9/13), 1 SN and 2 HHA visits were missed. During week 6 (3/10/13-3/16/13), 1 SN and 2 HHA visits were missed. 4. On 4-4-13 at 2:00 PM, employee A indicated there was no additional documentation available for record #3, #4, or #7 and the visits had been missed.		visit frequency listed in the plan of care is met. Target threshold for compliance is 95%. This will be tracked by the Performance Improvement Committee. The Director of Nursing or her designee will be responsible for implementing and monitoring these corrective measures to ensure the deficiency is corrected.	