

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 W LINCOLN HWY MERRILLVILLE, IN 46410
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N000000	<p>This was a home health state complaint investigation.</p> <p>Complaint IN 00128946 - Substantiated: State deficiencies related to the allegation are cited.</p> <p>Survey Date: June 10 - 13, 2013</p> <p>Facility #: IN003074</p> <p>Medicaid #: 200399420</p> <p>Surveyors: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 21, 2013</p>	N000000		

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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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, policy review, document review, and interview, the agency failed to ensure treatments had been provided as ordered on the written plan of care for 4 of (2, 3, 5, 6) of 7 records reviewed of patients with skilled nursing services with the potential to affect all patients receiving skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC 1/30/13) with a plan of care (POC) for the certification period of 3/30/13 - 5/29/13, failed to evidence the skilled nurse (SN) completed the oxygen saturation and weight checks as ordered on the plan of care (POC).</p> <p>a. The POC stated, "Monitor ... weight at Q [every] visit ... Monitor ... O2 [oxygen] SATs [saturation]." Nursing visits completed by Employee D on 4/3/13, 4/10/13, 4/17/13, 4/24/13, 5/1/13, 5/8/13, 5/15/13, and 5/22/13 failed to evidence the SN completed O2 Sats or weights at these visits. Employee D</p>	N000522	<p>1.No. 522 1.The Nursing Supervisor has inserviced the nursing staff that the patient's plan of care must be implemented as ordered by MD and dated per cert. Period. O2 sats, weight checks, abdominal girth measurements, and other parameters must be performed as ordered. Nursing job description is reviewed and signed by each nurse to ensure understanding of Case Manager responsibilities. 2.50% of all clinical records will be audited quarterly for evidence that the plan of care is implemented as ordered by MD. 100% of all plan of care with O2 sats, weights and abdominal girth measurements ordered will be audited on an ongoing basis. 3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

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	<p>documented at each of these visits that the patient was unable to stand and failed to notify the physician that the weights and O2 Sats had not been completed.</p> <p>b. On 6/12/13 at 4:05 PM, the director of nursing indicated the weights and O2 levels were not completed as ordered on the POC and sitting and standing scales were available for SN staff to take to nursing visits.</p> <p>2. Clinical record #3, SOC 1/9/13) with a POC for the certification period of 5/11/13 - 7/8/13, failed to evidence the SN monitored weights as ordered on the POC.</p> <p>a. The POC stated, "Notify MD [medical doctor] if patient gains 5 lbs [pounds] in one week or 2 lbs in one day." Documentation for SN visits completed by Employee E, RN, on 5/13/13, 5/20/13, and 5/27/13 evidenced the patient did not have a scale in the home and the weights were not monitored. The MD was not notified that the patient's weight was not being monitored.</p> <p>b. On 6/12/13 at 4:30 PM, the director of nursing indicated the POC was not followed for this patient.</p> <p>3. Clinical record #5, SOC 9/28/12 with a</p>						

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	<p>POC for the certification period of 11/27/13 - 1/25/13, failed to evidence the SN monitored the O2 Sats as ordered on the POC.</p> <p>a. The POC stated, "O2 Sat < [less than] 89 % Notify MD" A nursing visit completed by Employee E, RN, failed to evidence a completed O2 Sat level on 1/11/13.</p> <p>b. On 6/11/13 at 12:28 PM, Employee B, director of nursing, and Employee D, RN, indicated the POC was not followed for this nurse visit.</p> <p>4. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period of 4/5/13 - 6/3/12, failed to evidence the SN monitored O2 Sats, weights, and signs and symptoms of ascites, including tracking the abdominal girth.</p> <p>a. The POC stated, "SN: 1 wk [time a week] 9 [for 9 weeks] to observe / teach / perform: management and evaluation to ensure safe administration of nonskilled service ... ascites - monitor s / s [signs and symptoms] of exacerbation of ascites and effects on respiratory status ... Cardiac management: Monitor ... wt [weight]. Notify MD if O2 < 89 %." Nursing visits on 4/9/13, 4/15/13, 4/22/13, and 4/29/13 completed by Employee D, RN, failed to</p>			

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	<p>evidence O2 sat levels were monitored at any of these visits. Weights were not completed on 4/9/13 and 4/22/13. The record failed to evidence the abdominal girth had been measure at any visit by the SN.</p> <p>b. On 6/11/13 at 12:30 PM, Employee B, the director of nursing, and Employee D, RN, indicated the POC was not followed for patient #6 and the nurse did not monitor the abdominal girth and body.</p> <p>c. The agency document titled "Ascites" with no effective date stated, "Assessments 1. Daily measurement and recording of abdominal girth and body weight or as ordered by MD. 2. In a supine position, assess for the flank to bulge which indicates fluid accumulation in the peritoneal cavity. 3. Percussion for shifting dullness or detecting for fluid wave which indicates large accumulation of fluid. Nursing intervention 1. Teach about MD order / treatment 2. Nutrition - salt intake 3. Diuretics - electrolyte imbalance 4. Fluid intake 5. Care Coordination Goals 1. Daily weight loss should not exceed 1/2 lb per day 2. Maintenance of skin integrity."</p> <p>5. The agency policy titled "Skilled Nursing" with a review date of 1/1/13</p>			

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	<p>stated, "The skilled nurse is considered the case manager and as such is responsible for coordinating and / or supervising patient care to assure continuity and quality. The RN will function in accordance with the state's Nurse Practice Act and the agency policies ... Assessing the patient's present condition, including physical assessment, treatment needs, and current medications ... G. Initiating appropriate plan of care for skilled nurse intervention ... Providing direct care and / or instructing patient / family / caregiver in home care procedure per plan of treatment to assist patient in achieving jointly established goals."</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> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements and a timely physician signature for 3 (#1, #4, #6) of 7 clinical records reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p>	N000524	<ol style="list-style-type: none"> 1.The Nursing Supervisor has inserviced nursing staff that the plan of care must include all required elements such as full side rails, ted hose and other durable medical equipments and timely dated and signed by MD. 2.100% audit on supplies/equipment section of POT for evidence that all elements of POT is included, signed and dated timely by MD. 3.The Nursing Supervisor will be responsible for monitoring 	07/01/2013			

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	<p>1. Clinical record #1, start of care (SOC) 1/14/13 with a plan of care for the certification period of 5/14/13 - 7/12/13, failed to evidence the registered nurse obtained orders for full side rails on the patient's hospital bed.</p> <p>a. On 6/10/13 at 3:28 PM, patient #1 was observed in a hospital bed that had full side rails on the right side of the bed.</p> <p>b. On 6/11/13 at 1 PM, the director of nursing indicated the registered nurse had not obtained orders for full side rails for patient #1 and that the full side rails were not on the durable medical equipment list.</p> <p>2. Clinical record #4, SOC 10/16/09 with a plan of care for the certification period of 3/29/13 - 5/27/13, failed to evidence a physician's signature until 5/7/13.</p> <p>On 6/11/13 at 11:30 AM, the director of nursing indicated the physician's signature was not signed timely.</p> <p>3. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period 4/5/13 - 6/3/12, included documentation the patient wore ted hose bilaterally. The record failed to evidence the registered nurse obtained orders for the ted hose.</p> <p>A nurse visit note on 4/15/13 with a</p>		these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>signature of Employee D, registered nurse, stated, "Use of Ted hose to reduce edema bilaterally."</p> <p>4. The agency policy titled "Physician Orders" with a review date of 1/1/13 stated, "Physician's orders [Physician's Medical Plan of Treatment] should specify services, treatment, and supplies to be provided by the agency ... any continued lack of progress toward goals, unusual symptoms or reactions are to be reported to the patient physician." (60 days). The following information should be included in the plan of treatment ... Medications and treatments ... Types of services and medical supplies required ... orders for skilled nursing to include assessments, skilled intervention, instructions to patient and family ... other appropriate items."</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 clinical record review, policy review, document review, and interview, the agency failed to ensure skilled nursing services were in accordance with the plan of care for 4 of (2, 3, 5, 6) of 7 records reviewed of patients with skilled nursing services with the potential to affect all patients receiving skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC 1/30/13) with a plan of care (POC) for the certification period of 3/30/13 - 5/29/13, failed to evidence the skilled nurse (SN) completed the oxygen saturation and weight checks as ordered on the plan of care (POC).</p> <p>a. The POC stated, "Monitor ... weight at Q [every] visit ... Monitor ... O2 [oxygen] SATs [saturation]." Nursing visits completed by Employee D on 4/3/13, 4/10/13, 4/17/13, 4/24/13, 5/1/13, 5/8/13, 5/15/13, and 5/22/13 failed to evidence the SN completed O2 Sats or weights at these visits. Employee D documented at each of these visits that the</p>	N000537	<p>1.) The Nursing Supervisor has inserviced the nursing staff that the patient's plan of care must be implemented as ordered by MD and dated per cert. Period. O2 sats, weight checks, abdominal girth measurements, and other parameters must be performed as ordered. Nursing job description is reviewed and signed by each nurse to ensure understanding of Case Manager responsibilities.</p> <p>2.) 50% of all clinical records will be audited quarterly for evidence that the plan of care is implemented as ordered by MD. 100% of all plan of care with O2 sats, weights and abdominal girth measurements ordered will be audited on an ongoing basis.</p> <p>3.) The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

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	<p>patient was unable to stand and failed to notify the physician that the weights and O2 Sats had not been completed.</p> <p>b. On 6/12/13 at 4:05 PM, the director of nursing indicated the weights and O2 levels were not completed as ordered on the POC and sitting and standing scales were available for SN staff to take to nursing visits.</p> <p>2. Clinical record #3, SOC 1/9/13) with a POC for the certification period of 5/11/13 - 7/8/13, failed to evidence the SN monitored weights as ordered on the POC.</p> <p>a. The POC stated, "Notify MD [medical doctor] if patient gains 5 lbs [pounds] in one week or 2 lbs in one day." Documentation for SN visits completed by Employee E, RN, on 5/13/13, 5/20/13, and 5/27/13 evidenced the patient did not have a scale in the home and the weights were not monitored. The MD was not notified that the patient's weight was not being monitored.</p> <p>b. On 6/12/13 at 4:30 PM, the director of nursing indicated the POC was not followed for this patient.</p> <p>3. Clinical record #5, SOC 9/28/12 with a POC for the certification period of</p>			

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	<p>11/27/13 - 1/25/13, failed to evidence the SN monitored the O2 Sats as ordered on the POC.</p> <p>a. The POC stated, "O2 Sat < [less than] 89 % Notify MD" A nursing visit completed by Employee E, RN, failed to evidence a completed O2 Sat level on 1/11/13.</p> <p>b. On 6/11/13 at 12:28 PM, Employee B, director of nursing, and Employee D, RN, indicated the POC was not followed for this nurse visit.</p> <p>4. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period of 4/5/13 - 6/3/12, failed to evidence the SN monitored O2 Sats, weights, and signs and symptoms of ascites, including tracking the abdominal girth.</p> <p>a. The POC stated, "SN: 1 wk [time a week] 9 [for 9 weeks] to observe / teach / perform: management and evaluation to ensure safe administration of nonskilled service ... ascites - monitor s / s [signs and symptoms] of exacerbation of ascites and effects on respiratory status ... Cardiac management: Monitor ... wt [weight]. Notify MD if O2 < 89 %." Nursing visits on 4/9/13, 4/15/13, 4/22/13, and 4/29/13 completed by Employee D, RN, failed to evidence O2 sat levels were monitored at</p>						

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	<p>any of these visits. Weights were not completed on 4/9/13 and 4/22/13. The record failed to evidence the abdominal girth had been measure at any visit by the SN.</p> <p>b. On 6/11/13 at 12:30 PM, Employee B, the director of nursing, and Employee D, RN, indicated the POC was not followed for patient #6 and the nurse did not monitor the abdominal girth and body.</p> <p>c. The agency document titled "Ascites" with no effective date stated, "Assessments 1. Daily measurement and recording of abdominal girth and body weight or as ordered by MD. 2. In a supine position, assess for the flank to bulge which indicates fluid accumulation in the peritoneal cavity. 3. Percussion for shifting dullness or detecting for fluid wave which indicates large accumulation of fluid. Nursing intervention 1. Teach about MD order / treatment 2. Nutrition - salt intake 3. Diuretics - electrolyte imbalance 4. Fluid intake 5. Care Coordination Goals 1. Daily weight loss should not exceed 1/2 lb per day 2. Maintenance of skin integrity."</p> <p>5. The agency policy titled "Skilled Nursing" with a review date of 1/1/13 stated, "The skilled nurse is considered</p>						

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	<p>the case manager and as such is responsible for coordinating and / or supervising patient care to assure continuity and quality. The RN will function in accordance with the state's Nurse Practice Act and the agency policies ... Assessing the patient's present condition, including physical assessment, treatment needs, and current medications ... G. Initiating appropriate plan of care for skilled nurse intervention ...</p> <p>Providing direct care and / or instructing patient / family / caregiver in home care procedure per plan of treatment to assist patient in achieving jointly established goals."</p>			

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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on home visit observation, clinical record review, and interview, the agency failed to ensure the registered nurse had obtained all orders for the plan of care for 2 (#1, #6) of 7 records with skilled nursing with the potential to affect all of the agency's skilled nurse patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 1/14/13 with a plan of care for the certification period of 5/14/13 - 7/12/13, failed to evidence the registered nurse obtained orders for full side rails on the patient's hospital bed.</p> <p>a. On 6/10/13 at 3:28 PM, patient #1 was observed in a hospital bed that had full side rails on the right side of the bed.</p> <p>b. On 6/11/13 at 1 PM, the director of nursing indicated the registered nurse had not obtained orders for full side rails for patient #1 and that the full side rails were not on the durable medical equipment list.</p>	N000542	<p>1.The Nursing Supervisor has inserviced nursing staff that the plan of care must include all required elements such as full side rails, ted hose and other durable medical equipments and timely dated and signed by MD. 2.100% audit on supplies/equipment section of POT for evidence that all elements of POT is included, signed and dated timely by MD. 3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2013
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	<p>2. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period 4/5/13 - 6/3/12, included documentation the patient wore ted hose bilaterally. The record failed to evidence the registered nurse obtained orders for the ted hose.</p> <p>A nurse visit note on 4/15/13 with a signature of Employee D, registered nurse, stated, "Use of Ted hose to reduce edema bilaterally."</p>			