

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/06/2013
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NAME OF PROVIDER OR SUPPLIER ALLIANCE HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9615 N COLLEGE AVE INDIANAPOLIS, IN 46280
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N0000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: February 4-6, 2013</p> <p>Facility Number: 005843</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 20-25 Home Health Aide Only: 30-35 Personal Care Only: 125-130 Total: 153</p> <p>Sample: RR w/HV: 3 RR w/o HV: 2 Total: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 8, 2013</p>	N0000		

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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N0524	<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 policy review, record review, and observation, the agency failed to ensure the plan of care included all Durable Medical Equipment (DME) in 2 of 5 records reviewed with the potential to affect all the agency's patients. (#2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Plan of Care," 	N0524	N524 The Clinical Director will inservice the nursing staff on this regulation and what is required, to include that all durable medical equipment has been added to the plan of care. N524 Five visits will be done quarterly for evidence that all durable medical equipment is on the plan of care. Visits may be done during recerts/supervisory visits ongoing. The Clinical Director will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and	02/27/2013			

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	<p>policy number C-580 undated states,"The Plan of Care shall be completed in full to include: ... Medical supplies and equipment required."</p> <p>2. Clinical record #2, start of care 4/17/12, included a service provision plan dated 12/13/12 to 2/10/13. DME listed on the service provision plan included a walker, W/C (wheelchair), O2 (oxygen), and gloves.</p> <p>During a home visit on 2/5/13 at 9:45 AM, a bath bench and portable toilet handrails were observed in the bathroom. The service provision plan failed to evidence a bath bench and portable toilet handrails.</p> <p>3. Clinical record #3, start of care 4/23/09, included service provision plans dated 12/3/12 to 1/31/13 and 2/1/13 to 4/1/13. DME listed on the service provision plan included gloves, hospital bed, W/C, and walker.</p> <p>During a home visit on 2/5/13 at 11:15 AM, a bath bench was observed in bathroom. The plan of care failed to evidence a bath bench.</p>		will not recur.	

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N0608	<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 policy review, record review, and interview, the agency failed to ensure the clinical record included catheter care documentation in 1 of 5 records reviewed with the potential to affect all the agency's patients. (#4)</p> <p>The findings include:</p> <p>1. Facility policy titled "Clinical Documentation," policy number C-680 undated states, "All skilled services provided by Nursing, Therapy, or Social Services will be documented in the clinical record."</p>	N0608	N608 The Clinical Director will continue inservicing the home health aides on home health aide documentation and home health aide services. And that all services provided by the home health aide will be documented in the clinical record. Five percent of all clinical records will be audited quarterly for evidence that all services provided by the home helth aide will be documented in the clinical chart, ongoing. N608 The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	02/28/2013			

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	<p>2. Facility policy titled "Home Health Aide: Documentation," policy number C-800 undated states, "The Home Health Aide shall utilize the appropriate Home Health Aide flow sheet or charting form to document services rendered to the client."</p> <p>3. Facility policy titled "Home Health Aide Services," policy number C-220 undated states, "8. All services provided by the Home Health Aide shall be documented in the clinical record."</p> <p>4. Clinical record #4, start of care 12/21/12, included a Service Provision Plan from 12/21/12 to 2/18/13. Under the heading "Orders" the following were listed: HHA: 5-7 times per week for safety, assist in ADLs (Activities of Daily Living), monitor pressure points, empty foley times 60 days. Clinical record also included Home Health Aide Care Plan with orders under the heading "Procedures" for catheter care at every visit. Review of Weekly Visit Report for Home Health Aide (HHA) evidenced the following:</p> <p>A. On 1/21/13, 1/22/13, and 1/26/13, Catheter Care was not documented by HHAs.</p>			

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	B. On 2/6/13 at 3:40 PM, employee K, Alternate Administrator, indicated HHAs need to document if family preformed the task. At 3:41 PM, employee L, Registered Nurse Supervisor, indicated that family sometimes does this task but fails to inform the HHA for documentation purposes.			