

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2014
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NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 620 RIDGE RD MUNSTER, IN 46321
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G000000	<p>This was a Federal home health recertification survey. This was an extended survey.</p> <p>Survey date: 09/22, 09/23, 09/24, 09/25, and 09/26/14.</p> <p>Facility: 004658</p> <p>Medicaid Vendor: 200828630</p> <p>Surveyor: Shannon Pietraszewski, RN, BSN, PHNS</p> <p>Census: 121</p> <p>Total Home Health Services is precluded from providing a home health aide training and competency program for a period of 2 years beginning 09/26/14 for being found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Nursing Services; and 484.38 Clinical Records.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 15, 2014</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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G000107	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on agency document and policy review and interview, the agency failed to fully investigate complaints made by patients regarding treatment and care furnished by physical therapy for 4 of 12 complaints reviewed for 2014.</p> <p>Findings include:</p> <p>1. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... "</p> <p>2. A policy dated 11/14/08 titled "Clinical documentation" stated, "Any complaint from a patient or family / caregiver is to be documented on the patient complaint form by the person taking the call ... All complaints will be</p>	G000107	<p>1. The Director of Nursing developed a process to document and follow up on patient complaints regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the agency. The person receiving the complaint will document the details and any initial follow up on the Patient Complaint form and submit the form to the Director of Nursing (DON), who will take the necessary steps to resolve the problem to the patient's satisfaction. Office management and directors of all contracted services will be inserviced on this process. The Administrator revised Policy #25 (Clinical Documentation) to include that the complaint shall be documented within 24 hours of receipt, and that the involved department management, including contracted services,</p>	10/26/2014

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	<p>addressed by the supervisor or administrator and appropriate action swill be taken. In the event that the patient or family / caregiver does not feel the issue has been resolved to their satisfaction, they will be directed to use the Indiana Hot Line number provided in their folder ... "</p> <p>3. A policy dated 11/14/08 titled "Therapy services" stated, "Any deficiencies will be brought to the attention of the Director of Therapy. The Director will be responsible for instructing the therapist on these areas ...</p> <p>4. A complaint dated 07/11/14 indicated Employee L, a physical therapist, was to fill out a form of medical necessity regarding patient 11's mobility status for a DME (durable medical equipment) company for the patient to obtain a replacement chair. Patient 11 needed the form filled out in a "timely fashion" in order to have the chair before the patient was going on a trip. The patient indicated he/she had been asking Employee L "for weeks" and also had the DME provider in her home at the same time as Employee L to explain what forms needed to be filled out. Employee L asked the DME provider if he / she could fill out a different form without the narrative portion and was told by the</p>		<p>must document all investigations and resolutions. Complaint forms will be maintained in a binder entitled "Patient Complaints". 2. Every morning meeting, management will discuss any new complaints, and if follow up has begun. Director of Nursing will contact the parties involved, and forward the complaint form to the appropriate party for documentation. Director of Nursing will audit 100% of all complaints monthly for resolution and completed documentation. 3. The Director of Nursing will be responsible for ensuring that resolution is achieved and documented and for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>DME provider that would not be sufficient.</p> <p>a. Total Home Health Services contacted the contracting therapy company about the patient being upset and the form needed to be filled out as soon as possible. The contracted therapy company informed Total Home Health Services they would contact Employee L to fill out the form. The Director of Clinical services requested permission from the management team of Total Home Health Services if one could be rented for the patient to use for his/her trip, but "unfortunately one could not be obtained in time."</p> <p>b. The sections "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>5. A complaint dated 09/09/14 stated patient 14 canceled therapy due to the inconsistency and timing of appointments.</p> <p>a. Total Home Health Services contacted the contracting therapy company about the patient canceling physical therapy services due to conflict</p>				

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	<p>with timing with physical therapist and the patient.</p> <p>b. The sections "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>6. A complaint dated 09/09/14 stated patient 15 had an appointment with Employee P, a speech therapist, on 09/03/14 and the therapist did not show up. The spouse of patient 15 was concerned that she he had written the date and time wrong so the spouse contacted the therapist who apologized and stated that indeed the patient had an appointment on Wednesday but the therapist could not make the appointment and was having phone issues. Employee P rescheduled the appointment for Friday and Saturday and both days went by without the employee calling or showing up.</p> <p>a. Total Home Health Services contacted the contracting therapy company about patient 15's complaint. The form stated the contracting therapy company would speak with Employee P.</p> <p>b. The sections "Corrective Action</p>			

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	<p>Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>7. A complaint dated 09/12/14 stated patient 11 called to report Employee L had filled out the DME form incorrectly while she was out of town. Patient 11 reported the wrong type of chair was listed on the document and the documentation itself was insufficient; therefore, he/she was denied a chair.</p> <p>a. Total Home Health Services contacted the contracting therapy company as did patient 11 and was informed that corrective action would be taken, the form would be completed, and Employee L would be spoken to again.</p> <p>b. The section, "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>8. The Administrator indicated on 09/22/14 at 4:30 PM the therapy company was to follow up with the patient complaints, fill out the paperwork, and return the completed</p>				

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G000121	<p>document to the agency.</p> <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 observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the Centers for Disease Control "Standard Precautions" for 2 of 2 home health aide visit observations completed creating the potential to affect all of the agency's 31 current patients receiving home health aide services. (# 1 and 5)</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and</p>	G000121	<p>The Director of Nursing, Nursing Supervisor, and QI Coordinator will inservice all Home Health Aides on standard precautions and infection control. For a period of two years beginning 9/26/14, a qualified RN contracted from an outside source will conduct all initial and yearly Home Health Aide competency evaluations in accordance with ISDH CNA testing procedures. Competency in handwashing, glove technique, bathing, and perineal care will be verified on all currently employed Home Health Aides by 10/26/14 during provision of hands-on care of an agency patient or other consenting individual. RNs will monitor ongoing compliance during regularly scheduled supervisory visits.</p> <p>The Director of Nursing is responsible for verifying that the competency visits have occurred, and for monitoring ongoing</p>	10/26/2014

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	<p>transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. A home visit was made to patient # 1</p>		compliance with standard precautions so that the deficiency will not recur.	

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	<p>on 09/23/14 at 12:00 PM with Employee B, a home health aide (HHA). During the home visit, Employee B was observed taking the patient's temperature and removing the sheath from the thermometer without wearing gloves. Employee B was then observed assisting patient # 1 with washing the patient's back and buttock area while wearing gloves. Using the same gloves, Employee B assisted the patient with drying the patient's backside and lower extremities. Continuing to use the same gloves, Employee B assisted the patient with dressing. During this time, Employee S, Quality Assurance Nurse, indicated Employee B should have changed his / her gloves between bathing and drying and after drying the patient.</p> <p>3. A home visit was made to patient # 5 on 09/25/14 at 11:15 AM with Employee E, a home health aide. During the home visit, Employee E was observed assisting patient # 5 with taking a shower and cleaning his back and peri area. Employee E was observed to assist the patient with drying without changing her gloves. Employee E had the patient sit on top of his towel, which was covering the toilet seat, while drying and applying clothes to the lower extremities. After dressing the patient, Employee E was observed shaving the patient, assisting</p>			

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G000143	<p>with teeth brushing. The employee then had the patient use the same towel the patient was sitting on, to wipe his face and mouth area. During this time, Employee G, Clinical Supervisor, indicated Employee E should have obtained a clean towel for the patient to use on his / her face.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73 current patients receiving more than one service. (# 2, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14</p>	G000143	The QI coordinator will inservice all field staff and directors of contracted services on care coordination requirements and documentation, including patients' current status, progress to goals, and discharge planning. Case conferences will be held at least monthly or more often if necessary to facilitate coordination of care and address significant changes in the patient's condition that may affect interventions and outcomes. The contracted therapy directors will communicate this requirement to all therapy staff. The QI Coordinator will develop a tracking system for care	10/26/2014

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	<p>with orders for skilled nursing and physical and occupational therapy services. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for skilled nursing, home health aide, and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines after 07/18/14.</p> <p>3. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>4. Clinical record number 6, SOC 07/28/14, included a plan of care established by a physician for certification period 07/28/14 to 09/25/14</p>		<p>coordination and case conferencing between disciplines. All new admissions, recerts, and resumptions of care will be placed in the tracking system. The QI Coordinator will provide the RN case managers with a tracking calendar and will audit the medical record weekly for compliance and completeness of the case conferences.</p> <p>The QI Coordinator will be responsible for monitoring compliance on 100% of patients on an ongoing basis to ensure that this deficiency is corrected and will not recur. Findings will be reviewed at the QI committee meetings to determine the need for continued monitoring.</p>				

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	<p>with orders for skilled nursing and physical therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>A PTA (physical therapy assistant) note dated 08/05/14 stated the patient's pain was "horrible" over the weekend. The patient informed the PTA her medication had been changed and the patient was to take the pain medication every 8 hours but the pain would return around the "6 hour" mark. The clinical record failed to indicate if the PTA had informed the PT (physical therapist) or the skilled nurse in regards to the patient's increased pain and medication changes.</p> <p>5. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>6. Clinical record number 8, SOC</p>			

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	<p>06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for skilled nursing and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>7. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>8. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>9. An undated policy titled "Job Description Registered Nurse" stated, "Coordinates the plan of care with other disciplines through regular communication about changes, updates,</p>			

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G000144	<p>progress to goals, and discharge planning. Attends client care conferences per agency protocol and initiates as needed. "</p> <p>10. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... The responsibility for participating in developing plans of care ... "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73</p>	G000144	The Administrator developed Policy #45, Coordination of Services, that delineates specific requirements of patient care coordination including discussing and documenting current status, progress to goals, significant changes in condition, and discharge planning. The QI coordinator will inservice all field	10/26/2014

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	<p>current patients receiving more than one service. (# 2, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing and physical and occupational therapy services. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals. 2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for skilled nursing, home health aide, and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines after 07/18/14. 3. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing, home health aide, and physical therapy. The clinical record 		<p>staff and directors of contracted services on these requirements. The directors of contracted services will be responsible for ensuring that all associated service providers have been informed of these requirements. The supervisors or other designated staff will review therapy notes to ensure that any significant changes in condition were reported to the RN case manager. The QI Coordinator will develop a tracking system for care coordination and case conferencing between disciplines. All new admissions, recerts, and resumptions of care will be placed in the tracking system. The QI Coordinator will provide the RN case managers with a tracking calendar and will audit the medical record weekly for compliance and completeness of the case conferences. The QI Coordinator will be responsible for monitoring compliance on 100% of patients to ensure that this deficiency is corrected and does not recur.</p>	

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NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 620 RIDGE RD MUNSTER, IN 46321
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	<p>failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>4. Clinical record number 6, SOC 07/28/14, included a plan of care established by a physician for certification period 07/28/14 to 09/25/14 with orders for skilled nursing and physical therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>A PTA (physical therapy assistant) note dated 08/05/14 stated the patient's pain was "horrible" over the weekend. The patient informed the PTA her medication had been changed and the patient was to take the pain medication every 8 hours but the pain would return around the "6 hour" mark. The clinical record failed to indicate if the PTA had informed the PT (physical therapist) or the skilled nurse in regards to the patient's increased pain and medication changes.</p> <p>5. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14</p>			

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	<p>with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>6. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for skilled nursing and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>7. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>8. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to</p>			

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G000156	<p>provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>9. An undated policy titled "Job Description Registered Nurse" stated, "Coordinates the plan of care with other disciplines through regular communication about changes, updates, progress to goals, and discharge planning. Attends client care conferences per agency protocol and initiates as needed. "</p> <p>10. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... The responsibility for participating in developing plans of care ... "</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record and agency policy review and interview, it was determined the agency failed to ensure visits had been provided as ordered for 5 of 10 records reviewed and orders for assessment and teaching were carried out in 2 of 10 records reviewed creating the</p>	G000156	All staff will be educated on policy revision of Clinical documentation Policy. All staff will be inserviced on those items specified in Plan of Correction to G158,G159, and G165. Chart audits will be done according to Plan of Correction details as outlined in G158, G159, and	10/26/2014

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G000158	<p>potential to affect all of the agency's 121 current patients receiving services (See G 158); failed to ensure the plan of care was revised and updated to include all durable medical equipment and medications for 3 of 10 records reviewed physician orders were written in a timely manner, and home health aide duties were specified creating the potential to affect all of the agency's 121 current patients (See G 159); and failed to ensure medications and treatments were administered as ordered by the physician in 1 of 10 records reviewed creating the potential to affect 1 of 1 patient's receiving IV therapy and 1 of 8 patients receiving wound care treatments (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484. Acceptance of Patients, Plan of Care, & Medical Supervision.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a</p>		G165. The Director of Nursing will be responsible for monitoring the corrective actions to ensure that this condition is corrected and will not recur in G158, G159, and G165. This is our Statement of Credible Allegation of Compliance and Correction.		

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	<p>doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered for 5 of 10 records reviewed (# 2, 5, 7, 8, 9) and orders for assessment and teaching were carried out in 2 of 10 records reviewed (#5 and 8) creating the potential to affect all of the agency's 121 current patients receiving services.</p> <p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks.</p> <p>a. The clinical record evidence skilled nursing visits had been provided 4 times a week for weeks numbered 3, 4, and 5.</p> <p>b. The plan of care included orders for blood draws through the patient's central line that stated, "waste 6 cc [cubic centimeters], flush with 10 cc NS [normal saline], 5 cc Heparin 100 U [units] / ml [milliliters]." Skilled nursing visits dated 08/20, 09/01, 09/07, 09/08,</p>	G000158	<p>The Administrator revised policy #25, Clinical Documentation, to state that any changes to the patient Plan of Care must be by physician order, and that all orders must be written within 48 hours. The Director of Nursing will inservice all clinical staff and directors of contracted services regarding the organization's current policies on writing and following physician orders; making changes to the Plan of Care; documenting missed visits; and addressing all aspects of the Plan of Care including assessment, interventions, teaching, patient or caregiver understanding, and progress to goals. Directors of contracted services were provided with a copy of this policy as well as the contracted services policy on performing the evaluations within 48 hours of the initiation or resumption of services. The directors of contracted services will communicate the same to all therapy staff. To ensure this is being followed, the Administrator adapted the EMR process to include relevant document tracking. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be</p>	10/26/2014

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	<p>and 09/15/14 stated that the central line was flushed with 10 cc of Normal Saline before and after blood draws The visit records failed to evidence if the central line had been flushed with heparin.</p> <p>c. The plan of care indicated the patient was receiving treatment to a stump wound with a wound vac daily. The wound vac was to be changed 3 times a week and as needed. During a home visit on 09/23/14 at 9:30 AM, the skilled nurse was observed applying sulfa cream to the patient's wound prior to applying foam to the wound bed. The record failed to evidence an order for the sulfa cream.</p> <p>2. Clinical record number 5, SOC 06/13/14, included a plan of care with a certification period of 08/12/14 to 10/10/14 with orders for home health aide services 2 times a week for 9 weeks. A physician's order dated 07/27/14 ordered home health aide services 2 times a week for 3 weeks. The clinical record failed to evidence home health aide visit notes between 08/04/14 to 08/14/14.</p> <p>The plan of care also included orders for skilled nursing to evaluate nutrition / hydration, GI status, GU status, depression, instruct on disease process / management, signs and symptoms</p>		responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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	<p>warranting attention, diet, infection precautions, home safety / fall precautions, skin care, energy conservation, and pressure ulcer prevention. A skilled nurse visit note dated 08/18/14, 08/27/14, 09/10/14, and 09/24/14 failed to indicate if the GI / GU and depression status had been assessed and failed to indicate if any teaching and caregiver understanding had been provided.</p> <p>3. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for physical, occupational, and speech therapy. On 03/11/14, the patient was transferred to the hospital and returned on 03/18/14.</p> <p>a. The patient resumed services on 03/18/14 with orders for physical therapy 1 time for an evaluation then 2 times a week for 7 weeks. The physical therapist made an extra visit between the week of 03/30/14 and 04/05/14.</p> <p>b. On 04/11/14, the patient resumed services again with orders for physical therapy 1 time a week for 1 week then 2 times a week for 3 weeks and speech therapy 1 time a week for 1 week then 2 times a week for 4 weeks. The physical</p>			

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	<p>therapist failed to make two visits during the week of 04/27/14 to 05/03/14. Speech therapy failed to make two visits between the week of 04/27/14 to 05/03/14 and 05/04/14 to 05/07/14.</p> <p>4. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for occupational therapy. The occupational therapist failed to follow the plan of care within 48 hours of admission.</p> <p>The plan of care also included orders for skilled nursing to teach medication set up. Skilled nursing visit notes dated 06/25/14, 06/30/14, 07/02/14, 07/09/14, 07/16/14, 07/23/14, and 07/30/14 failed to evidence that medication set up was provided / taught.</p> <p>5. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for speech therapy. The speech therapist failed to follow the plan of care within 48 hours of admission.. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of</p>			

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G000159	<p>the exit conference on 09/26/14 at 3:45 PM.</p> <p>6. A policy titled "Contracted Services" dated 11/14/08 stated, "All contracted providers will see patients within 48 hours of receiving the referral. If the provider does not see the patient within 48 hours, the provider must call the supervisor and complete a written communication detailing the reason for the delay ... "</p> <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. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care was revised and updated to include all durable medical equipment (DME) and medications for 3 of 10 records reviewed (# 1, 3, 5), physician orders were written in a timely manner in 2 of 10 records</p>	G000159	The Director of Nursing will inservice all clinical staff on the Plan of Care requirements including proper documentation of all DME equipment in the home, allergies, diet, medication, treatments, and authorization to accept orders from all treating physicians; reconciling the Plan of Care with facility discharge	10/26/2014

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	<p>reviewed (# 2 and 5), and home health aide duties were specified in 2 of 10 records reviewed (# 1 and 4) creating the potential to affect all of the agency's 121 current patients.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14.</p> <p>a. During a home visit on 09/23/14 at 12:00 PM, the patient was observed to have a toilet seat riser, grab bars, and beside commode. The plan of care failed to include all DME equipment in the home.</p> <p>b. The plan of care stated the home health aide was to provide bathing and ADL (activities of daily living) assistance. The plan of care failed to be specific with the duties of the home health aide in the home.</p> <p>c. The plan of care stated the patient's diet was 1800 Cal ADA, Cardiac, 2 Liters of fluids. On 07/06/14, discharge instructions from the hospital stated the patient's diet was a Healthy Heart: 2 gram low sodium, low cholesterol, low fat diet. The plan of care</p>		<p>summaries at any initiation or resumption of services; writing physician orders within 48 hours; and ensuring that Home Health Aide care plans are patient specific. All field RNs will be required to come into the office to complete the newly implemented patient-specific Home Health Aide care plans. To ensure this is being followed, the Administrator adapted the EMR process to include relevant document tracking.</p> <p>The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%.</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>failed to be revised and updated for the current certification period.</p> <p>d. The medication profile evidence the patient was receiving metaxalone 400 mg (milligrams) twice a day, lasix tablet 40 mg twice a day, and protonix 40 mg twice a day. A hospital discharge summary dated 07/07/14 stated the patient was to receive metaxalone 400 mg as needed, lasix 40 mg at 9 AM and 5 PM, and protonix before meals. The plan of care failed to be revised at resumption of care.</p> <p>2. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks. The plan of care indicated the patient was allergic to Vancomycin.</p> <p>a. A physicians order dated 09/24/14 stated, "Wound care to R [right] stump frequency BID [twice a day]. Cleanse with saline, saline wet - dry drsg [dressing], wrap with kerlix secured with tape ... " The date to begin was 08/18/14 and discontinued date was 08/20/14.</p> <p>b. A physician order dated 09/24/14 stated, "Cleanse R stump with saline, pat</p>			

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	<p>dry, wound vac to be applied every M - W - Fri @ 125 mm [millimeters/hg [mercury] /continuous." The begin date was 08/20/14 and discontinued date 09/22/14.</p> <p>c. During a home visit on 09/24/14 at 9:30 AM, the skilled nurse was following up with the patient and spouse in regards to the change of fluids from normal saline to dextrose mixed with the Vancomycin for IV infusion. The spouse stated the patient was not allergic to Vancomycin but would get the "Red Man Syndrome" and would need to be premedicated with antihistamines prior to IV administration. The spouse also stated the patient was receiving Novolog R sliding scale insulin. The plan of care failed to be updated and revised to include Dextrose versus the Normal Saline for IV antibiotic administration, failed to indicate the patient was receiving Novolog R sliding scale insulin, and to discontinue the allergy to Vancomycin.</p> <p>3. Clinical record # 3, SOC 09/12/14, included a plan of care established by a physician for certification period 09/12/14 to 11/10/14 for skilled nursing and physical and occupational therapy.</p> <p>During a home visit on 09/24/14 at</p>			

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	<p>1:00 PM, patient number 3 was observed to have an oxygen concentrator with humidification, 5 e-cylinders (portable oxygen), and a portable oxygen cart to carry the e-cylinders. The plan of care failed to evidence the oxygen concentrator, humidification, e - cylinders, and portable cart.</p> <p>4. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 for home health aide 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's. The plan of care failed to be specific with the duties of the home health aide in the home.</p> <p>5. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing to provide wound care and obtain blood for PT/INR [laboratory test].</p> <p>a. A physician's order dated 08/21/14 stated to give coumadin oral tablet 2.5 mg (milligrams) daily except Thursdays and Sundays and 5 mg on Thursdays and Sundays. Four diagonal lines was marked a cross the signature lines with a handwritten message "Managed by</p>						

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	<p>Cardiologist." The plan of care failed to include orders could be accepted from the cardiologist.</p> <p>b. A physician's order dated 09/22/14 included orders for the skilled nurse to provide services starting on 06/29/14. The plan of care failed to evidence the physician orders were timely.</p> <p>c. A physician's order dated 09/22/14 included orders for the skilled nurse to provide starting on 06/13/14. The plan of care failed to evidence the physician orders were timely.</p> <p>d. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/06/14. The plan of care failed to evidence the physician orders were timely.</p> <p>e. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/20/14. The plan of care failed to evidence the physician orders were timely.</p> <p>6. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p>						

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G000165	<p>7. An undated policy titled "Job Description Registered Nurse" stated, "Evaluates and regularly re - evaluates the nursing needs of the client, develops, evaluates, and updates the plan of care ..."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure medications and treatments were administered as ordered by the physician in 1 of 10 records reviewed creating the potential to affect 1 of 1 patient's receiving IV therapy and 1 of 8 patients receiving wound care treatments. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record # 2, start of care</p>	G000165	<p>The Administrator revised policy #25, Clinical Documentation, to include that any changes to the Plan of Care must be by physician order. The Director of Nursing will inservice all clinical staff regarding the organization's current policies on writing and following physician orders, making changes to the Plan of Care, and administering drugs and treatments only as ordered by the physician. The nursingsupervisors, QI Coordinator, and other designated staff will audit 75%</p>	10/26/2014

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	<p>08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks.</p> <p>a. The plan of care ordered blood draws through the patient's central line as "waste 6 cc [cubic centimeters, flush with 10 cc NS [normal saline], 5 cc Heparin 100 U [units] / ml [milliliters]." Skilled nursing visit notes dated 08/20, 09/01, 09/07, 09/08, and 09/15/14 stated that the central line was flushed with 10 cc of Normal Saline before and after blood draws The clinical records failed to evidence if the central line had been flushed with heparin.</p> <p>b. The plan of care indicated the patient was receiving treatment to a stump wound with a wound vac daily. The wound vac was to be changed 3 times a week and as needed. During a home visit on 09/23/14 at 9:30 AM, the skilled nurse was observed applying sulfa cream to the patient's wound prior to applying foam to the wound bed. The record failed to evidence an order for the sulfa cream.</p> <p>2. The Administrator, Director of Clinical Services, Therapy Director, and</p>		<p>ofcurrent clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G000168	<p>Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>3. An undated job description for Registered Nurses stated, "Job Duties / Knowledge ... Demonstrates competency in nursing skills including [but not limited to] ... wound care, infusion therapy and site maintenance, wound care including wound vac ... "</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to ensure medications and treatments were administered as ordered by the physician in 1 of 10 records reviewed creating the potential to affect 1 of 1 patient's receiving IV therapy and 1 of 8 patients receiving wound care treatments (See G 170); failed to ensure the Registered Nurse revised and updated the plan of care to include all durable medical equipment, medications, and treatments for 4 of 10 records reviewed, changes in frequency of discipline visits timely, and specific home health aide duties creating the potential to affect all of the agency's 121 current patients (See G 173); and failed to ensure the Registered Nurse</p>	G000168	<p>All staff and Contracted Therapy Directors to be educated on the Plan of Care requirements, changes made to the plan of care, and the coordination of all care between all disciplines involved in the patient care. The items are specified under G170, G173, and G176. Chart audits will be done according to Plan of Correction details as outlined in G170, G173, and G176. The Director of Nursing will be responsible for monitoring the corrective actions to ensure that this condition is corrected and will not recur concerning G170 and G173. The QI Coordinator will be responsible for monitoring the corrective actions to ensure that this condition is corrected and will not recur concerning G176. This is our Statement of Credible</p>	10/26/2014

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G000170	<p>communicated with all disciplines to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73 current patients receiving more than one service (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30: Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure medications and treatments were administered as ordered by the physician in 1 of 10 records reviewed creating the potential to affect 1 of 1 patient's receiving IV therapy and 1 of 8 patients receiving wound care treatments. (# 2)</p> <p>Findings include:</p>	G000170	<p>Allegation of Compliance and Correction.</p> <p>The Director of Nursing will inservice all clinical staff regarding the organization's current policies on writing and following physician orders, making</p>	10/26/2014

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	<p>1. Clinical record # 2, start of care 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks.</p> <p>a. The plan of care ordered blood draws through the patient's central line as "waste 6 cc [cubic centimeters, flush with 10 cc NS [normal saline], 5 cc Heparin 100 U [units] / ml [milliliters]." Skilled nursing visit notes dated 08/20, 09/01, 09/07, 09/08, and 09/15/14 stated that the central line was flushed with 10 cc of Normal Saline before and after blood draws The clinical records failed to evidence if the central line had been flushed with heparin.</p> <p>b. The plan of care indicated the patient was receiving treatment to a stump wound with a wound vac daily. The wound vac was to be changed 3 times a week and as needed. During a home visit on 09/23/14 at 9:30 AM, the skilled nurse was observed applying sulfa cream to the patient's wound prior to applying foam to the wound bed. The record failed to evidence an order for the sulfa cream.</p> <p>2. The Administrator, Director of</p>		<p>changes to the Plan of Care, and administering drugs and treatments only as ordered by the physician.</p> <p>The nursing Supervisors, QI Coordinator, and other designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%.</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will</p>				

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G000173	<p>Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>3. An undated job description for Registered Nurses stated, "Job Duties / Knowledge ... Demonstrates competency in nursing skills including [but not limited to] ... wound care, infusion therapy and site maintenance, wound care including wound vac ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the Registered Nurse revised and updated the plan of care to include all durable medical equipment (DME), medications, and treatments for 4 of 10 records reviewed (# 1, 2, 3, 5); changes in frequency of discipline visits in a timely manner (# 2 and 5); and specific home health aide duties (# 1 and 4) creating the potential to affect all of the agency's 121 current patients.</p>	G000173	<p>not recur.</p> <p>The Director of Nursing will inservice all clinical staff regarding the requirements to: 1) document all required elements in the Plan of Care, including all DME equipment in the home, allergies, diet, medication, treatments, and authorization to accept orders from all treating physicians; 2) reconcile the Plan of Care with facility discharge summaries at any initiation or resumption of services; 3) write a physician order for any Plan of Care changes within 48 hours. If it is discovered that the clinician failed to write an order for a plan</p>	10/26/2014

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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14.</p> <p>a. During a home visit on 09/23/14 at 12:00 PM, the patient was observed to have a toilet seat riser, grab bars, and beside commode. The registered nurse failed to update the plan of care to include all DME equipment in the home.</p> <p>b. The plan of care stated the home health aide was to provide bathing and ADL (activities of daily living) assistance. The registered nurse failed to update the plan of care with specific duties of the home health aide in the home.</p> <p>c. The plan of care stated the patient's diet was 1800 Cal ADA, Cardiac, 2 Liters of fluids. On 07/06/14, discharge instructions from the hospital stated the patient's diet was a Healthy Heart: 2 gram low sodium, low cholesterol, low fat diet. The registered nurse failed to updated the plan of care for the current certification period.</p> <p>d. The medication profile evidence</p>		<p>of care change, the order will immediately be written, will include the statement "Late entry", and will include the date on which the new order was initiated; 5) follow physician orders when administering all drugs and treatments; and 6) provide patient-specific details on the HHA careplan. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>the patient was receiving metaxalone 400 mg (milligrams) twice a day, lasix tablet 40 mg twice a day, and protonix 40 mg twice a day. A hospital discharge summary dated 07/07/14 stated the patient was to receive metaxalone 400 mg as needed, lasix 40 mg at 9 AM and 5 PM, and protonix before meals. The registered nurse failed to update the plan of care at resumption of care.</p> <p>2. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks. The plan of care indicated the patient was allergic to Vancomycin.</p> <p>a. A physicians order dated 09/24/14 stated, "Wound care to R [right] stump frequency BID [twice a day]. Cleanse with saline, saline wet - dry drsg [dressing], wrap with kerlix secured with tape ... " The date to begin was 08/18/14 and discontinued date was 08/20/14.</p> <p>b. A physician order dated 09/24/14 stated, "Cleanse R stump with saline, pat dry, wound vac to be applied every M - W - Fri @ 125 mm [millimeters/hg [mercury] /continuous." The begin date was 08/20/14 and discontinued date</p>			

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	<p>09/22/14.</p> <p>c. During a home visit on 09/24/14 at 9:30 AM, the skilled nurse was following up with the patient and spouse in regards to the change of fluids from normal saline to dextrose mixed with the Vancomycin for IV infusion. The spouse stated the patient was not allergic to Vancomycin but would get the "Red Man Syndrome" and would need to be premedicated with antihistamines prior to IV administration. The spouse also stated the patient was receiving Novolog R sliding scale insulin. The registered nurse failed to update the plan of care to include Dextrose versus the Normal Saline for IV antibiotic administration, failed to indicate the patient was receiving Novolog R sliding scale insulin, and to discontinue the allergy to Vancomycin.</p> <p>3. Clinical record # 3, SOC 09/12/14, included a plan of care established by a physician for certification period 09/12/14 to 11/10/14 for skilled nursing and physical and occupational therapy.</p> <p>During a home visit on 09/24/14 at 1:00 PM, patient number 3 was observed to have an oxygen concentrator with humidification, 5 e-cylinders (portable oxygen), and a portable oxygen cart to</p>			

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	<p>carry the e-cylinders. The registered nurse failed to update the plan of care to evidence the oxygen concentrator, humidification, e - cylinders, and portable cart.</p> <p>4. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 for home health aide 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's. The registered nurse failed to update the plan of care with the specific duties of the home health aide in the home.</p> <p>5. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing to provide wound care and obtain blood for PT/INR [laboratory test].</p> <p>a. A physician's order dated 08/21/14 stated to give coumadin oral tablet 2.5 mg (milligrams) daily except Thursdays and Sundays and 5 mg on Thursdays and Sundays. Four diagonal lines was marked a cross the signature lines with a handwritten message "Managed by Cardiologist." The registered nurse failed to update the plan of care to include</p>			

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	<p>orders could be accepted from the cardiologist.</p> <p>b. A physician's order dated 09/22/14 included orders for the skilled nurse to provide services starting on 06/29/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>c. A physician's order dated 09/22/14 included orders for the skilled nurse to provide starting on 06/13/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>d. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/06/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>e. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/20/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>6. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p>			

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G000176	<p>7. An undated policy titled "Job Description Registered Nurse" stated, "Evaluates and regularly re - evaluates the nursing needs of the client, develops, evaluates, and updates the plan of care ..."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse communicated with all disciplines to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73 current</p>	G000176	The QI coordinator will inservice all field staff and directors of contracted services regarding the care coordination, progress to goals documentation, and discharge planning required in the care coordination documentation. Case conferencing shall be completed at least monthly and	10/26/2014

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	<p>patients receiving more than one service. (# 2, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing and physical and occupational therapy services. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals. 2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for skilled nursing, home health aide, and physical and occupational therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines after 07/18/14. 3. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing, home health aide, and physical therapy. The clinical record 		<p>more often if necessary to facilitate multidisciplinary coordination of patient care and to report any significant changes in the patient's condition. The QI Coordinator will develop a tracking system for care coordination and case conferencing between disciplines. All new admissions, recerts, and resumptions of care will be placed in the tracking system. The QI Coordinator will provide the RN case managers with a tracking calendar and will audit the medical record weekly for compliance and completeness of the case conferences.</p> <p>The QI Coordinator will be responsible for monitoring compliance on 100% of patients to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>4. Clinical record number 6, SOC 07/28/14, included a plan of care established by a physician for certification period 07/28/14 to 09/25/14 with orders for skilled nursing and physical therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>5. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>6. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for skilled nursing and physical and occupational therapy. The</p>			

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	<p>clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>7. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>8. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>9. An undated policy titled "Job Description Registered Nurse" stated, "Coordinates the plan of care with other disciplines through regular communication about changes, updates, progress to goals, and discharge planning. Attends client care conferences per agency protocol and initiates as needed. "</p>			

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G000186	<p>10. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... The responsibility for participating in developing plans of care ... "</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered for 3 of 10 records reviewed (# 7, 8, and 9) creating the potential to affect all 71 physical therapy, 23 occupational therapy, and 5 speech therapy patients currently receiving therapy services.</p> <p>Findings include:</p> <p>1. Clinical record number 7, start of care (SOC) 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14</p>	G000186	The Director of Nursing will inservice the directors of all contracted services regarding the organization's current policies on writing and following physician orders; making changes to the Plan of Care; documenting missed visits; and performing evaluations within 48 hours of the initiation or resumption of services. The directors of contracted services will communicate the same to all therapy staff. The nursing Supervisors, QI Coordinator, and any designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the	10/26/2014

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	<p>with orders for physical, occupational, and speech therapy. On 03/11/14, the patient was transferred to the hospital and returned on 03/18/14.</p> <p>a. The patient resumed services on 03/18/14 with orders for physical therapy 1 time for an evaluation then 2 times a week for 7 weeks. The physical therapist made an extra visit between the week of 03/30/14 and 04/05/14.</p> <p>b. On 04/11/14, the patient resumed services again with orders for physical therapy 1 time a week for 1 week then 2 times a week for 3 weeks and speech therapy 1 time a week for 1 week then 2 times a week for 4 weeks. The physical therapist failed to make two visits during the week of 04/27/14 to 05/03/14. Speech therapy failed to make two visits between the week of 04/27/14 to 05/03/14 and 05/04/14 to 05/07/14.</p> <p>2. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for occupational therapy. The occupational therapist failed to follow the plan of care within 48 hours of admission.</p> <p>3. Clinical record number 9, SOC</p>		<p>number of charts audited will be reduced to 50%. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G000224	<p>09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for speech therapy. The speech therapist failed to follow the plan of care within 48 hours of admission.</p> <p>4. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>5. A policy titled "Contracted Services" dated 11/14/08 stated, "All contracted providers will see patients within 48 hours of receiving the referral. If the provider does not see the patient within 48 hours, the provider must call the supervisor and complete a written communication detailing the reason for the delay ... "</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate</p>			

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	<p>professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure that the home health aide care plan was revised to include patient diagnoses and duties to avoid while providing patient care for 2 of 10 records reviewed creating the potential to affect all 31 current patients who were receiving home health aide services.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14 with orders for home health aide services 2 times a week for 9 weeks to assist with bathing and ADLs (activities of daily living). The plan of care stated the patient had a diagnosis of diabetes mellitus type 2.</p> <p>a. The home health aide care plan stated the patient's diagnosis is congestive heart failure only. Assigned tasks included foot care and nail care. Last updated care plan in the patient's folder at home was dated 09/22/13 prior to the recent updated care plan of 09/23/14.</p>	G000224	<p>A new Home Health Aide care plan will be used to allow patient specific documentation including comorbid diagnoses and specific care parameters. The Director of Nursing will inservice the RNs on HHA careplan requirements, including the need to update the careplan with any changes. The HHAs will be inserviced regarding the requirement to follow the plan, document the reason that any ordered service was not provided, and notify the RN if a patient is continually refusing an ordered service. The new care plan and visit documentation note will be completed and implemented on all patients. The nursing Supervisors, QI Coordinator, and any designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	10/26/2014

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	<p>b. The Registered Nurse failed to update the home health aide care plan to include diagnosis of diabetes mellitus type 2 and to remove the tasks of foot and nail care and / or instruct home health aide file toe and fingernails only and not to trim the toe nails and fingernails.</p> <p>2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for home health aide services 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's.</p> <p>a. The home health aide care plan dated 08/19/14 stated the patient was to receive a complete bed and bath.</p> <p>b. Home health aide visit notes dated 08/25, 08/28, 09/03, 09/08, 09/12, 09/16, 09/18/14 evidenced the home health had been giving the patient a shower, massage, and "tidy" the patient's care area. The Registered Nurse failed to update the home health aide care plan to include showers, massage, and to "tidy" patient care area.</p> <p>3. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to</p>			
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G000225	<p>provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>4. An undated policy titled "Home Health Aide Competency Evaluation" stated, "Written patient care instructions will be prepared by the RN [registered nurse] or therapy case manager, and a copy will be left in the patient chart. HHAs [home health aides] must follow the careplan on every visit; any deviation must be noted on the chart with an explanation i.e. [example] patient refused and the case manager should be notified ... "</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide provided services as ordered by the physician in 2 of 10 records reviewed creating the potential to affect all current 31 patients receiving home health aide services. (# 5 and 7)</p>	G000225	The Director of Nursing will inservice all field staff regarding the organization's current policies on writing and following physician orders; making changes to the Plan of Care; and documenting missed visits; and coordinating care with HHAs to include frequencies and the HHA care plan. The nursing Supervisors, QI Coordinator, and other designated staff will audit 75% of	10/26/2014

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G000236	<p>policy review, and interview, it was determined the agency failed to ensure the home health aide only recorded the tasks that were provided after they had been provided for 1 of 2 home health aide observations creating the potential to affect all 31 patients receiving home health aide services with the agency (See G 236).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.48: Clinical Records.</p> <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. Based on observation, clinical record and policy review, and interview, the agency failed to ensure the home health aide only recorded the tasks that were provided</p>	G000236	<p>the HHA care plan requirements, compliance with the care given to the patient, and proper documentation of the visit, as outlined in G236 Plan of Correction. Field staff RN's will verify compliance with HHA supervisory visits. The Director of Nursing will be responsible for monitoring the corrective actions to ensure that this condition is corrected and will not recur in G236. This is our Statement of Credible Allegation of Compliance and Correction.</p> <p>The Director of Nursing will inservice and re-instruct all Home Health Aides on proper documentation of duties performed in accordance with the</p>	10/26/2014

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	<p>after they had been provided for 1 of 2 home health aide observations creating the potential to affect all 31 patients receiving home health aide services with the agency. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14 with orders for the home health aide to assist with bathing and ADLs (activities of daily living) 2 times a week for 9 weeks.</p> <p>a A home visit was made to patient # 1 on 09/23/14 at 12:00 PM with Employee B, a home health aide (HHA). During the home visit, Employee B was observed to have marked the home health aide visit note with duties that were to be completed and had the patient sign the form prior to providing any duties. Duties checked off as being completed were assist with toileting, foot care, nail care, denture / oral care, shampoo (comb / brush), hair care, skin care, and lotion. The home health aide failed to perform these duties nor did she ask the patient to assist with these duties.</p> <p>b. Upon completing the visit,</p>		<p>care plan, including that documentation must be completed and signed by the patient only after the care is provided. Director of Nursing will inservice field staff RN's on HHA compliance with visit documentation. Field staff RN's will verify compliance during supervisory visits. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G000321	<p>Employee S, Quality Assurance, indicated the home health aide should not have pre-marked the duties and should have asked the patient if he / she wanted the tasks completed.</p> <p>2. An undated policy titled "Home Health Aide Competency Evaluation" stated, "Written patient care instructions will be prepared by the RN or therapy case manager, and a copy will be left in the patient chart. HHAs [home health aides] must follow the careplan on every visit; any deviation must be noted on the chart with an explanation i.e. [example] patient refused and the case manager should be notified ... "</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review, agency policy review, and interview, the agency failed to ensure OASIS data had been transmitted to the state agency within 30 days of the date the assessment was completed in 2 of 10 records reviewed of patients whose OASIS data should have been transmitted creating the potential to</p>	G000321	The Administrator will inservice nursing supervisors on EMR alerts and the process for monitoring the alerts for any OASIS that has not been transmitted. The Administrator will inservice the OASIS transmission personnel that if a warning is received it is to be given to the nursing supervisors to investigate and identify the cause of the warning. To	10/26/2014

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	<p>affect all of the agency's patients whose OASIS data is required to be transmitted. (# 4 and 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 09/14/14 evidenced a resumption of care assessment had been completed on 05/25/14 for patient number 4. The document evidenced the OASIS data had not been transmitted until 06/30/14. 2. An ISDH document dated 09/14/14 evidenced a start of care assessment had been completed on 03/09/14 for patient number 7. The document evidenced the OASIS data had not been transmitted until 08/08/14. The document evidenced a transfer assessment had been completed on 03/11/14 and had not been transmitted until 08/08/14. The document evidenced a discharge assessment had been completed on 06/30/14 and had not been transmitted until 08/08/14. The document failed to include a transfer assessment between two consecutive resumption of care assessments between 03/18/14 and 04/11/14. 3. Employee D, a Clinical Supervisor, indicated on 09/26/14 at 11:55 AM the transfer assessment was not completed on patient number 7. 		<p>ensure compliance, the Director of Nursing will check the alerts weekly for untransmitted OASIS and the transmission personnel will bring every transmission record with out of sequence warning to the Director of Nursing. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G000337	<p>4. A policy titled "Clinical Record Policy" dated 09/20/11 stated, "Completion of Records and Transmission of OASIS Files ... Data will be transmitted no less frequently than monthly for the previous month's records ..."</p> <p>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 clinical record review and interview, the agency failed to ensure the medication profile was updated with correct dosage and directions for 2 of 10 records reviewed creating the potential to affect all of the agency's 121 current patients. (# 1 and 2)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14.</p> <p>a. The medication profile evidence</p>	G000337	The Director of Nursing will inservice all clinical staff regarding the required elements of the comprehensive assessment, including review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The nursing Supervisors, QI Coordinator, and any designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of	10/26/2014

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	<p>the patient was receiving metaxalone 400 mg (milligrams) twice a day, lasix tablet 40 mg twice a day, and protonix 40 mg twice a day.</p> <p>b. A hospital discharge summary dated 07/07/14 stated the patient was to receive metaxalone 400 mg as needed, lasix 40 mg at 9 AM and 5 PM, and protonix before meals. The medication profile failed to be revised at resumption of care.</p> <p>2. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14.</p> <p>During a home visit on 09/24/14 at 9:30 AM, the skilled nurse was following up with the patient and spouse in regards to the change of fluids from normal saline to dextrose mixed with the Vancomycin for IV infusion. The spouse stated the patient was not allergic to Vancomycin but would get the "Red Man Syndrome" and would need to be premedicated with antihistamines prior to IV administration. The spouse also stated the patient was receiving Novolog R sliding scale insulin. The medication profile failed to be updated and revised to include Dextrose versus the Normal Saline for IV antibiotic administration,</p>		Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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G000341	<p>failed to indicate the patient was receiving Novolog R sliding scale insulin, and the allergy to Vancomycin be removed.</p> <p>3. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>4. A policy titled "Clinical Record Policy" dated 09/20/11 stated, "The contents of a clinical record include ... Medication record which includes the ...allergies or prior adverse reactions, all prescription and non - prescription drugs with route, dosage, frequency ... and review / revision information ... "</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure a transfer assessment was completed when a patient was transferred to the hospital in 1 of 10 records reviewed of patients whose OASIS data should have been</p>	G000341	Director of Nursing will inservice field staff RN's of the need to complete a transfer OASIS within 48 hours of discovering a patient has been admitted to an inpatient facility. The Administrator will inservice the OASIS transmission personnel that if a	10/26/2014

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N000000	<p>transmitted creating the potential to affect all of the agency's patients who are transferred to the hospital. (# 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 09/14/14 evidenced a start of care assessment had been completed on 03/09/14 for patient number 7. The document evidenced the OASIS data had not been transmitted until 08/08/14. The document evidenced a transfer assessment had been completed on 03/11/14 and had not been transmitted until 08/08/14. The document evidenced a discharge assessment had been completed on 06/30/14 and had not been transmitted until 08/08/14. The document failed to include a transfer assessment between two consecutive resumption of care assessments between 03/18/14 and 04/11/14. 2. Employee D, a Clinical Supervisor, indicated on 09/26/14 at 11:55 AM the transfer assessment was not completed on patient number 7. <p>This was a State home health relicensure survey.</p> <p>Survey date: 09/22, 09/23, 09/24, 09/25,</p>	N000000	<p>warning is received that states the OASIS is out of sequence, it is to be given to the Nursing supervisors, to investigate and identify the cause of the warning.</p> <p>To ensure compliance, the Nursing supervisors will verify that a transfer OASIS has been completed when a Resumption of Care occurs. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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N000470	<p>and 09/26/14.</p> <p>Facility: 004658</p> <p>Medicaid Vendor: 200828630</p> <p>Surveyor: Shannon Pietraszewski, RN, BSN, PHNS</p> <p>Census: 121</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 15, 2014</p> <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 observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the Centers for Disease Control "Standard Precautions" for 2 of 2 home health aide visit observations completed creating the potential to affect all of the agency's 31 current patients receiving home health aide services. (# 1 and 5)</p> <p>The findings include:</p>	N000470	The Director of Nursing, Nursing Supervisor, and QI Coordinator will inservice all Home Health Aides on standard precautions and infection control. For a period of two years beginning 9/26/14, a qualified RN contracted from an outside source will conduct all initial and yearly Home Health Aide competency evaluations in accordance with ISDH CNA testing procedures. Competency in handwashing, glove technique, bathing, and perineal care will be	10/26/2014

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	<p>1. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . .</p>		<p>verified on all currently employed Home Health Aides by 10/26/14/14 during provision of hands-on care of an agency patient or other consenting individual. RNs will monitor ongoing compliance during regularly scheduled supervisory visits.</p> <p>The Director of Nursing is responsible for verifying that the competency visits have occurred, and for monitoring ongoing compliance with standard precautions so that the deficiency will not recur.</p>	

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	<p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. A home visit was made to patient # 1 on 09/23/14 at 12:00 PM with Employee B, a home health aide (HHA). During the home visit, Employee B was observed taking the patient's temperature and removing the sheath from the thermometer without wearing gloves. Employee B was then observed assisting patient # 1 with washing the patient's back and buttock area while wearing gloves. Using the same gloves, Employee B assisted the patient with drying the patient's backside and lower extremities. Continuing to use the same gloves, Employee B assisted the patient with dressing. During this time, Employee S, Quality Assurance Nurse, indicated Employee B should have changed his / her gloves between bathing and drying and after drying the patient.</p> <p>3. A home visit was made to patient # 5 on 09/25/14 at 11:15 AM with Employee E, a home health aide. During the home visit, Employee E was observed assisting patient # 5 with taking a shower and cleaning his back and peri area.</p>			

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N000484	<p>Employee E was observed to assist the patient with drying without changing her gloves. Employee E had the patient sit on top of his towel, which was covering the toilet seat, while drying and applying clothes to the lower extremities. After dressing the patient, Employee E was observed shaving the patient, assisting with teeth brushing. The employee then had the patient use the same towel the patient was sitting on, to wipe his face and mouth area. During this time, Employee G, Clinical Supervisor, indicated Employee E should have obtained a clean towel for the patient to use on his / her face.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73 current patients receiving more than one</p>	N000484	The QI coordinator will inservice all field staff and directors of contracted services on care coordination requirements and documentation, including patients' current status, progress to goals, and discharge planning. Case conferences will be held at least monthly or more often if	10/26/2014

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	<p>service. (# 2, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing and physical and occupational therapy services. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for skilled nursing, home health aide, and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines after 07/18/14.</p> <p>3. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence documentation of</p>		<p>necessary to facilitate coordination of care and address significant changes in the patient's condition that may affect interventions and outcomes. The contracted therapy directors will communicate this requirement to all therapy staff. The QI Coordinator will develop a tracking system for care coordination and case conferencing between disciplines. All new admissions, recerts, and resumptions of care will be placed in the tracking system. The QI Coordinator will provide the RN case managers with a tracking calendar and will audit the medical record weekly for compliance and completeness of the case conferences.</p> <p>The QI Coordinator will be responsible for monitoring compliance on 100% of patients on an ongoing basis to ensure that this deficiency is corrected and will not recur. Findings will be reviewed at the QI committee meetings to determine the need for continued monitoring.</p>	

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	<p>coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>4. Clinical record number 6, SOC 07/28/14, included a plan of care established by a physician for certification period 07/28/14 to 09/25/14 with orders for skilled nursing and physical therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>A PTA (physical therapy assistant) note dated 08/05/14 stated the patient's pain was "horrible" over the weekend. The patient informed the PTA her medication had been changed and the patient was to take the pain medication every 8 hours but the pain would return around the "6 hour" mark. The clinical record failed to indicate if the PTA had informed the PT (physical therapist) or the skilled nurse in regards to the patient's increased pain and medication changes.</p> <p>5. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for skilled nursing, home</p>			

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	<p>health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>6. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for skilled nursing and physical and occupational therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>7. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence documentation of coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>8. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the</p>			

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N000514	<p>end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>9. An undated policy titled "Job Description Registered Nurse" stated, "Coordinates the plan of care with other disciplines through regular communication about changes, updates, progress to goals, and discharge planning. Attends client care conferences per agency protocol and initiates as needed. "</p> <p>10. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... The responsibility for participating in developing plans of care ... "</p> <p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on</p>			

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	<p>behalf of the home health agency.</p> <p>(2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on agency document and policy review and interview, the agency failed to fully investigate complaints made by patients regarding treatment and care furnished by physical therapy for 4 of 12 complaints reviewed for 2014.</p> <p>Findings include:</p> <p>1. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... "</p> <p>2. A policy dated 11/14/08 titled "Clinical documentation" stated, "Any complaint from a patient or family / caregiver is to be documented on the patient complaint form by the person taking the call ... All complaints will be addressed by the supervisor or administrator and appropriate action will be taken. In the event that the patient or family / caregiver does not feel the issue has been resolved to their satisfaction, they will be directed to use the Indiana Hot Line number provided in their folder ... "</p>	N000514	<p>The Director of Nursing developed a process to document and followup on patient complaints regarding treatment or care that is (or fails to be)furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the agency. The person receiving the complaint will document the details and any initial follow up on the Patient Complaint form and submit the form to the Director of Nursing (DON), who will be responsible for ensuring that the necessary steps are taken to resolve the problem to the patient's satisfaction. The DON will ensure that additional follow up and resolution is documented. Office management and directors of all contracted services will be inserviced on thisprocess.</p> <p>TheAdministrator revised Policy #25 (Clinical Documentation) to include that the complaint shall be documented within 24 hours of receipt, and that the involved department management, including contracted services, must document all investigations and resolutions. Complaint forms will be maintained in a binder entitled "Patient Complaints". Every morning meeting management to discuss any new complaints, and if follow up has</p>	10/26/2014

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	<p>3. A policy dated 11/14/08 titled "Therapy services" stated, "Any deficiencies will be brought to the attention of the Director of Therapy. The Director will be responsible for instructing the therapist on these areas ...</p> <p>4. A complaint dated 07/11/14 indicated Employee L, a physical therapist, was to fill out a form of medical necessity regarding patient 11's mobility status for a DME (durable medical equipment) company for the patient to obtain a replacement chair. Patient 11 needed the form filled out in a "timely fashion" in order to have the chair before the patient was going on a trip. The patient indicated he/she had been asking Employee L "for weeks" and also had the DME provider in her home at the same time as Employee L to explain what forms needed to be filled out. Employee L asked the DME provider if he / she could fill out a different form without the narrative portion and was told by the DME provider that would not be sufficient.</p> <p>a. Total Home Health Services contacted the contracting therapy company about the patient being upset and the form needed to be filled out as soon as possible. The contracted therapy company informed Total Home Health</p>		<p>begun. Director of Nursing will contact the parties involved, and forward the complaint form to the appropriate party for documentation. Director of Nursing will audit 100% of all complaints monthly for resolution and completed documentation. The Director of Nursing will be responsible for ensuring that resolution is achieved and documented.</p>	

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	<p>Services they would contact Employee L to fill out the form. The Director of Clinical services requested permission from the management team of Total Home Health Services if one could be rented for the patient to use for his/her trip, but "unfortunately one could not be obtained in time."</p> <p>b. The sections "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>5. A complaint dated 09/09/14 stated patient 14 canceled therapy due to the inconsistency and timing of appointments.</p> <p>a. Total Home Health Services contacted the contracting therapy company about the patient canceling physical therapy services due to conflict with timing with physical therapist and the patient.</p> <p>b. The sections "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p>			

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	<p>6. A complaint dated 09/09/14 stated patient 15 had an appointment with Employee P, a speech therapist, on 09/03/14 and the therapist did not show up. The spouse of patient 15 was concerned that she he had written the date and time wrong so the spouse contacted the therapist who apologized and stated that indeed the patient had an appointment on Wednesday but the therapist could not make the appointment and was having phone issues. Employee P rescheduled the appointment for Friday and Saturday and both days went by without the employee calling or showing up.</p> <p>a. Total Home Health Services contacted the contracting therapy company about patient 15's complaint. The form stated the contracting therapy company would speak with Employee P.</p> <p>b. The sections "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>7. A complaint dated 09/12/14 stated patient 11 called to report Employee L had filled out the DME form incorrectly</p>						

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N000522	<p>while she was out of town. Patient 11 reported the wrong type of chair was listed on the document and the documentation itself was insufficient; therefore, he/she was denied a chair.</p> <p>a. Total Home Health Services contacted the contracting therapy company as did patient 11 and was informed that corrective action would be taken, the form would be completed, and Employee L would be spoken to again.</p> <p>b. The section, "Corrective Action Taken," "Further follow up required," and patient follow up were left blank. There was lack of evidence to indicate the complaint was investigated and resolved to the patient's satisfaction.</p> <p>8. The Administrator indicated on 09/22/14 at 4:30 PM the therapy company was to follow up with the patient complaints, fill out the paperwork, and return the completed document to the agency.</p> <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:</p>			

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered for 5 of 10 records reviewed (# 2, 5, 7, 8, 9) and orders for assessment and teaching were carried out in 2 of 10 records reviewed (#5 and 8) creating the potential to affect all of the agency's 121 current patients receiving services.</p> <p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks.</p> <p>a. The clinical record evidence skilled nursing visits had been provided 4 times a week for weeks numbered 3, 4, and 5.</p> <p>b. The plan of care included orders for blood draws through the patient's central line that stated, "waste 6 cc [cubic centimeters], flush with 10 cc NS [normal saline], 5 cc Heparin 100 U [units] / ml [milliliters]." Skilled nursing visits dated 08/20, 09/01, 09/07, 09/08, and 09/15/14 stated that the central line was flushed with 10 cc of Normal Saline</p>	N000522	<p>The Administrator revised policy #25, Clinical Documentation, to state that any changes to the patient Plan of Care must be by physician order, and that all orders must be written within 48 hours. The Director of Nursing will inservice all clinical staff and directors of contracted services regarding the organization's current policies on writing and following physician orders;making changes to the Plan of Care; documenting missed visits; and addressing all aspects of the Plan of Care including assessment, interventions, teaching, patient or caregiver understanding, and progress to goals. Directors of contracted services were provided with a copy of this policy as well as the contracted services policy on performing the evaluations within 48 hours of the initiation or resumption of services. The directors of contracted services will communicate the same to all therapy staff. To ensure this is being followed, the Administrator adapted the EMR process to include relevant document tracking. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical documentation for 2 months. If 90% compliance is achieved,the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective</p>	10/26/2014

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	<p>before and after blood draws The visit records failed to evidence if the central line had been flushed with heparin.</p> <p>c. The plan of care indicated the patient was receiving treatment to a stump wound with a wound vac daily. The wound vac was to be changed 3 times a week and as needed. During a home visit on 09/23/14 at 9:30 AM, the skilled nurse was observed applying sulfa cream to the patient's wound prior to applying foam to the wound bed. The record failed to evidence an order for the sulfa cream.</p> <p>2. Clinical record number 5, SOC 06/13/14, included a plan of care with a certification period of 08/12/14 to 10/10/14 with orders for home health aide services 2 times a week for 9 weeks. A physician's order dated 07/27/14 ordered home health aide services 2 times a week for 3 weeks. The clinical record failed to evidence home health aide visit notes between 08/04/14 to 08/14/14.</p> <p>The plan of care also included orders for skilled nursing to evaluate nutrition / hydration, GI status, GU status, depression, instruct on disease process / management, signs and symptoms warranting attention, diet, infection precautions, home safety / fall</p>		actions to ensure that this deficiency is corrected and will not recur.				

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	<p>precautions, skin care, energy conservation, and pressure ulcer prevention. A skilled nurse visit note dated 08/18/14, 08/27/14, 09/10/14, and 09/24/14 failed to indicate if the GI / GU and depression status had been assessed and failed to indicate if any teaching and caregiver understanding had been provided.</p> <p>3. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for physical, occupational, and speech therapy. On 03/11/14, the patient was transferred to the hospital and returned on 03/18/14.</p> <p>a. The patient resumed services on 03/18/14 with orders for physical therapy 1 time for an evaluation then 2 times a week for 7 weeks. The physical therapist made an extra visit between the week of 03/30/14 and 04/05/14.</p> <p>b. On 04/11/14, the patient resumed services again with orders for physical therapy 1 time a week for 1 week then 2 times a week for 3 weeks and speech therapy 1 time a week for 1 week then 2 times a week for 4 weeks. The physical therapist failed to make two visits during the week of 04/27/14 to 05/03/14.</p>			

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	<p>Speech therapy failed to make two visits between the week of 04/27/14 to 05/03/14 and 05/04/14 to 05/07/14.</p> <p>4. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for occupational therapy. The occupational therapist failed to follow the plan of care within 48 hours of admission.</p> <p>The plan of care also included orders for skilled nursing to teach medication set up. Skilled nursing visit notes dated 06/25/14, 06/30/14, 07/02/14, 07/09/14, 07/16/14, 07/23/14, and 07/30/14 failed to evidence that medication set up was provided / taught.</p> <p>5. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for speech therapy. The speech therapist failed to follow the plan of care within 48 hours of admission.. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p>			

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N000524	<p>6. A policy titled "Contracted Services" dated 11/14/08 stated, "All contracted providers will see patients within 48 hours of receiving the referral. If the provider does not see the patient within 48 hours, the provider must call the supervisor and complete a written communication detailing the reason for the delay ... "</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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. Based on clinical record and policy</p>	N000524	The Director of Nursing will	10/26/2014			

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	<p>review, observation, and interview, the agency failed to ensure the plan of care was revised and updated to include all durable medical equipment (DME) and medications for 3 of 10 records reviewed (# 1, 3, 5), physician orders were written in a timely manner in 2 of 10 records reviewed (# 2 and 5), and home health aide duties were specified in 2 of 10 records reviewed (# 1 and 4) creating the potential to affect all of the agency's 121 current patients.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14.</p> <p>a. During a home visit on 09/23/14 at 12:00 PM, the patient was observed to have a toilet seat riser, grab bars, and beside commode. The plan of care failed to include all DME equipment in the home.</p> <p>b. The plan of care stated the home health aide was to provide bathing and ADL (activities of daily living) assistance. The plan of care failed to be specific with the duties of the home health aide in the home.</p>		<p>inservice all clinical staff on the Plan of Care requirements including proper documentation of all DME equipment in the home, allergies, diet, medication, treatments, and authorization to accept orders from all treating physicians; reconciling the Plan of Care with facility discharge summaries at any initiation or resumption of services; writing physician orders within 48 hours; and ensuring that Home Health Aide care plans are patient specific. All field RNs will be required to come into the office to complete the newly implemented patient-specific Home Health Aide care plans. To ensure this is being followed, the Administrator adapted the EMR process to include relevant document tracking. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical documentation for 2months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>c. The plan of care stated the patient's diet was 1800 Cal ADA, Cardiac, 2 Liters of fluids. On 07/06/14, discharge instructions from the hospital stated the patient's diet was a Healthy Heart: 2 gram low sodium, low cholesterol, low fat diet. The plan of care failed to be revised and updated for the current certification period.</p> <p>d. The medication profile evidence the patient was receiving metaxalone 400 mg (milligrams) twice a day, lasix tablet 40 mg twice a day, and protonix 40 mg twice a day. A hospital discharge summary dated 07/07/14 stated the patient was to receive metaxalone 400 mg as needed, lasix 40 mg at 9 AM and 5 PM, and protonix before meals. The plan of care failed to be revised at resumption of care.</p> <p>2. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks. The plan of care indicated the patient was allergic to Vancomycin.</p> <p>a. A physicians order dated 09/24/14 stated, "Wound care to R [right] stump frequency BID [twice a day]. Cleanse</p>			

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	<p>with saline, saline wet - dry drsg [dressing], wrap with kerlix secured with tape ... " The date to begin was 08/18/14 and discontinued date was 08/20/14.</p> <p>b. A physician order dated 09/24/14 stated, "Cleanse R stump with saline, pat dry, wound vac to be applied every M - W - Fri @ 125 mm [millimeters/hg [mercury] /continuous." The begin date was 08/20/14 and discontinued date 09/22/14.</p> <p>c. During a home visit on 09/24/14 at 9:30 AM, the skilled nurse was following up with the patient and spouse in regards to the change of fluids from normal saline to dextrose mixed with the Vancomycin for IV infusion. The spouse stated the patient was not allergic to Vancomycin but would get the "Red Man Syndrome" and would need to be premedicated with antihistamines prior to IV administration. The spouse also stated the patient was receiving Novolog R sliding scale insulin. The plan of care failed to be updated and revised to include Dextrose versus the Normal Saline for IV antibiotic administration, failed to indicate the patient was receiving Novolog R sliding scale insulin, and to discontinue the allergy to Vancomycin.</p>			

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	<p>3. Clinical record # 3, SOC 09/12/14, included a plan of care established by a physician for certification period 09/12/14 to 11/10/14 for skilled nursing and physical and occupational therapy.</p> <p>During a home visit on 09/24/14 at 1:00 PM, patient number 3 was observed to have an oxygen concentrator with humidification, 5 e-cylinders (portable oxygen), and a portable oxygen cart to carry the e-cylinders. The plan of care failed to evidence the oxygen concentrator, humidification, e - cylinders, and portable cart.</p> <p>4. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 for home health aide 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's. The plan of care failed to be specific with the duties of the home health aide in the home.</p> <p>5. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing to provide wound care and obtain blood for PT/INR [laboratory test].</p>			

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	<p>a. A physician's order dated 08/21/14 stated to give coumadin oral tablet 2.5 mg (milligrams) daily except Thursdays and Sundays and 5 mg on Thursdays and Sundays. Four diagonal lines was marked a cross the signature lines with a handwritten message "Managed by Cardiologist." The plan of care failed to include orders could be accepted from the cardiologist.</p> <p>b. A physician's order dated 09/22/14 included orders for the skilled nurse to provide services starting on 06/29/14. The plan of care failed to evidence the physician orders were timely.</p> <p>c. A physician's order dated 09/22/14 included orders for the skilled nurse to provide starting on 06/13/14. The plan of care failed to evidence the physician orders were timely.</p> <p>d. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/06/14. The plan of care failed to evidence the physician orders were timely.</p> <p>e. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/20/14. The plan of care failed to evidence the physician orders were timely.</p>				

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N000537	<p>6. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>7. An undated policy titled "Job Description Registered Nurse" stated, "Evaluates and regularly re - evaluates the nursing needs of the client, develops, evaluates, and updates the plan of care ..."</p> <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 and agency policy review and interview, the agency failed to ensure medications and treatments were administered as ordered by the physician in 1 of 10 records reviewed creating the potential to affect 1 of 1 patient's receiving IV therapy and 1 of 8 patients receiving wound care treatments. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record # 2, start of care</p>	N000537	The Administrator revised policy #25, Clinical Documentation, to include that any changes to the Plan of Care must be by physician order. The Director of Nursing will inservice all clinical staff regarding the organization's current policies on writing and following physician orders, making changes to the Plan of Care, and administering drugs and treatments only as ordered by the physician. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% of current clinical	10/26/2014

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	<p>08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks.</p> <p>a. The plan of care ordered blood draws through the patient's central line as "waste 6 cc [cubic centimeters, flush with 10 cc NS [normal saline], 5 cc Heparin 100 U [units] / ml [milliliters]." Skilled nursing visit notes dated 08/20, 09/01, 09/07, 09/08, and 09/15/14 stated that the central line was flushed with 10 cc of Normal Saline before and after blood draws The clinical records failed to evidence if the central line had been flushed with heparin.</p> <p>b. The plan of care indicated the patient was receiving treatment to a stump wound with a wound vac daily. The wound vac was to be changed 3 times a week and as needed. During a home visit on 09/23/14 at 9:30 AM, the skilled nurse was observed applying sulfa cream to the patient's wound prior to applying foam to the wound bed. The record failed to evidence an order for the sulfa cream.</p> <p>2. The Administrator, Director of Clinical Services, Therapy Director, and</p>		documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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N000542	<p>Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>3. An undated job description for Registered Nurses stated, "Job Duties / Knowledge ... Demonstrates competency in nursing skills including [but not limited to] ... wound care, infusion therapy and site maintenance, wound care including wound vac ... "</p> <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 clinical record and policy review, observation, and interview, the agency failed to ensure the Registered Nurse revised and updated the plan of care to include all durable medical equipment (DME), medications, and treatments for 4 of 10 records reviewed (# 1, 2, 3, 5); changes in frequency of discipline visits in a timely manner (# 2 and 5); and specific home health aide duties (# 1 and 4) creating the potential to</p>	N000542	The Director of Nursing will inservice all clinical staff regarding the requirements to: 1) document all required elements in the Plan of Care, including all DME equipment in the home, allergies, diet, medication, treatments, and authorization to acceptorders from all treating physicians; 2) reconcile the Plan of Care with facility discharge summaries at any initiation or resumption of services; 3)write a physician order for any Plan of	10/26/2014

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	<p>affect all of the agency's 121 current patients.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14.</p> <p>a. During a home visit on 09/23/14 at 12:00 PM, the patient was observed to have a toilet seat riser, grab bars, and beside commode. The registered nurse failed to update the plan of care to include all DME equipment in the home.</p> <p>b. The plan of care stated the home health aide was to provide bathing and ADL (activities of daily living) assistance. The registered nurse failed to update the plan of care with specific duties of the home health aide in the home.</p> <p>c. The plan of care stated the patient's diet was 1800 Cal ADA, Cardiac, 2 Liters of fluids. On 07/06/14, discharge instructions from the hospital stated the patient's diet was a Healthy Heart: 2 gram low sodium, low cholesterol, low fat diet. The registered nurse failed to updated the plan of care for the current certification period.</p>		<p>Care changes within 48 hours. If it is discovered that the clinician failed to write an order for a plan of care change, the order will immediately be written, will include the statement "Late entry", and will include the date on which the new order was initiated; 5)follow physician orders when administering all drugs and treatments; and 6)provide patient-specific details on the HHA careplan. The nursing supervisors, QI Coordinator, and other designated staff will audit 75% ofcurrent clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2014
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	<p>d. The medication profile evidence the patient was receiving metaxalone 400 mg (milligrams) twice a day, lasix tablet 40 mg twice a day, and protonix 40 mg twice a day. A hospital discharge summary dated 07/07/14 stated the patient was to receive metaxalone 400 mg as needed, lasix 40 mg at 9 AM and 5 PM, and protonix before meals. The registered nurse failed to update the plan of care at resumption of care.</p> <p>2. Clinical record # 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14 with orders for skilled nursing 4 times a week for 1 week then 3 times a week for 8 weeks. The plan of care indicated the patient was allergic to Vancomycin.</p> <p>a. A physicians order dated 09/24/14 stated, "Wound care to R [right] stump frequency BID [twice a day]. Cleanse with saline, saline wet - dry drsg [dressing], wrap with kerlix secured with tape ... " The date to begin was 08/18/14 and discontinued date was 08/20/14.</p> <p>b. A physician order dated 09/24/14 stated, "Cleanse R stump with saline, pat dry, wound vac to be applied every M - W - Fri @ 125 mm [millimeters/hg</p>			

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	<p>[mercury] /continuous." The begin date was 08/20/14 and discontinued date 09/22/14.</p> <p>c. During a home visit on 09/24/14 at 9:30 AM, the skilled nurse was following up with the patient and spouse in regards to the change of fluids from normal saline to dextrose mixed with the Vancomycin for IV infusion. The spouse stated the patient was not allergic to Vancomycin but would get the "Red Man Syndrome" and would need to be premedicated with antihistamines prior to IV administration. The spouse also stated the patient was receiving Novolog R sliding scale insulin. The registered nurse failed to update the plan of care to include Dextrose versus the Normal Saline for IV antibiotic administration, failed to indicate the patient was receiving Novolog R sliding scale insulin, and to discontinue the allergy to Vancomycin.</p> <p>3. Clinical record # 3, SOC 09/12/14, included a plan of care established by a physician for certification period 09/12/14 to 11/10/14 for skilled nursing and physical and occupational therapy.</p> <p>During a home visit on 09/24/14 at 1:00 PM, patient number 3 was observed to have an oxygen concentrator with</p>						

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	<p>humidification, 5 e-cylinders (portable oxygen), and a portable oxygen cart to carry the e-cylinders. The registered nurse failed to update the plan of care to evidence the oxygen concentrator, humidification, e - cylinders, and portable cart.</p> <p>4. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 for home health aide 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's. The registered nurse failed to update the plan of care with the specific duties of the home health aide in the home.</p> <p>5. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing to provide wound care and obtain blood for PT/INR [laboratory test].</p> <p>a. A physician's order dated 08/21/14 stated to give coumadin oral tablet 2.5 mg (milligrams) daily except Thursdays and Sundays and 5 mg on Thursdays and Sundays. Four diagonal lines was marked a cross the signature lines with a handwritten message "Managed by</p>			

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	<p>Cardiologist." The registered nurse failed to update the plan of care to include orders could be accepted from the cardiologist.</p> <p>b. A physician's order dated 09/22/14 included orders for the skilled nurse to provide services starting on 06/29/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>c. A physician's order dated 09/22/14 included orders for the skilled nurse to provide starting on 06/13/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>d. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/06/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>e. A physician's order dated 09/23/14 included orders for the skilled nurse to provide starting on 08/20/14. The registered nurse failed to ensure the plan of care orders were timely.</p> <p>6. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were not unable to provide any further documentation by the end of the exit conference on 09/26/14 at</p>			

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N000545	<p>3:45 PM.</p> <p>7. An undated policy titled "Job Description Registered Nurse" stated, "Evaluates and regularly re - evaluates the nursing needs of the client, develops, evaluates, and updates the plan of care ..."</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse communicated with all disciplines to ensure coordination of care while services were being provided for 7 of 10 records reviewed creating the potential to affect all of the agency's 73 current patients receiving more than one service. (# 2, 4, 5, 6, 7, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 08/08/14, included a plan of care established by a physician for certification period 08/18/14 to 10/16/14</p>	N000545	<p>The QI coordinator will inservice all field staff and directors of contracted services regarding the care coordination, progress to goals documentation, and discharge planning required in the care coordination documentation. Case conferencing shall be completed at least monthly and more often if necessary to facilitate multidisciplinary coordination of patient care and to report any significant changes in the patient's condition. The QI Coordinator will develop a tracking system for care coordination and case conferencing between disciplines. All new admissions, recerts, and resumptions of care</p>	10/26/2014			

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	<p>with orders for skilled nursing and physical and occupational therapy services. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for skilled nursing, home health aide, and physical and occupational therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines after 07/18/14.</p> <p>3. Clinical record 5, SOC 06/13/14, included a plan of care established by a physician for certification period 08/12/14 to 10/10/14 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>4. Clinical record number 6, SOC 07/28/14, included a plan of care established by a physician for certification period 07/28/14 to 09/25/14</p>		<p>will be placed in the tracking system. The QI Coordinator will provide the RN case managers with a tracking calendar and will audit the medical record weekly for compliance and completeness of the case conferences.</p> <p>The QI Coordinator will be responsible for monitoring compliance on 100% of patients to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>with orders for skilled nursing and physical therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>5. Clinical record number 7, SOC 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>6. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for skilled nursing and physical and occupational therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>7. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for</p>			

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	<p>certification period 09/02/14 to 10/31/14 with orders for skilled nursing, home health aide, and physical, occupational, and speech therapy. The clinical record failed to evidence the registered nurse provided coordination of care among all disciplines to include patient's current status and progress toward goals.</p> <p>8. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>9. An undated policy titled "Job Description Registered Nurse" stated, "Coordinates the plan of care with other disciplines through regular communication about changes, updates, progress to goals, and discharge planning. Attends client care conferences per agency protocol and initiates as needed. "</p> <p>10. A policy dated 11/14/08 titled "Contracted services" stated, "All contracted providers will sign a contract specifying the following ... The necessity to conform to all applicable agency policies and procedures ... The responsibility for participating in developing plans of care ... "</p>			

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a)(1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the agency failed to ensure that the home health aide care plan was revised to include patient diagnoses and duties to avoid while providing patient care for 2 of 10 records reviewed creating the potential to affect all 31 current patients who were receiving home health aide services.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14 with orders for home health aide services 2 times a week for 9 weeks to assist with bathing and ADLs (activities of daily living). The plan of care stated the patient had a diagnosis of diabetes mellitus type 2.</p> <p>a. The home health aide care plan</p>	N000550	<p>A new Home Health Aide care plan will be used to allow patient specific documentation including comorbid diagnoses and specific care parameters. The Director of Nursing will inservice the RNs on HHA care plan requirements, including the need to update the care plan with any changes. The HHAs will be inserviced regarding the requirement to follow the plan, document the reason that any ordered service was not provided, and notify the RN if a patient is continually refusing an ordered service. The new care plan and visit documentation note will be completed and implemented on all patients.. The nursing Supervisors, QI Coordinator, and any designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this</p>	10/26/2014

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	<p>stated the patient's diagnosis is congestive heart failure only. Assigned tasks included foot care and nail care. Last updated care plan in the patient's folder at home was dated 09/22/13 prior to the recent updated care plan of 09/23/14.</p> <p>b. The Registered Nurse failed to update the home health aide care plan to include diagnosis of diabetes mellitus type 2 and to remove the tasks of foot and nail care and / or instruct home health aide file toe and fingernails only and not to trim the toe nails and fingernails.</p> <p>2. Clinical record number 4, SOC 10/23/13, included a plan of care established by a physician for certification period 08/19/14 to 10/17/14 with orders for home health aide services 2 times a week for 9 weeks to assist with hygiene, personal care, and ADL's.</p> <p>a. The home health aide care plan dated 08/19/14 stated the patient was to receive a complete bed and bath.</p> <p>b. Home health aide visit notes dated 08/25, 08/28, 09/03, 09/08, 09/12, 09/16, 09/18/14 evidenced the home health had been giving the patient a shower, massage, and "tidy" the patient's care area. The Registered Nurse failed to</p>		deficiency is corrected and will not recur.	

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N000564	<p>update the home health aide care plan to include showers, massage, and to "tidy" patient care area.</p> <p>3. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>4. An undated policy titled "Home Health Aide Competency Evaluation" stated, "Written patient care instructions will be prepared by the RN [registered nurse] or therapy case manager, and a copy will be left in the patient chart. HHAs [home health aides] must follow the careplan on every visit; any deviation must be noted on the chart with an explanation i.e. [example] patient refused and the case manager should be notified ... "</p> <p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided</p>	N000564	TheDirector of Nursing will inservice the directors of all contracted services regarding the	10/26/2014

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	<p>as ordered for 3 of 10 records reviewed (# 7, 8, and 9) creating the potential to affect all 71 physical therapy, 23 occupational therapy, and 5 speech therapy patients currently receiving therapy services.</p> <p>Findings include:</p> <p>1. Clinical record number 7, start of care (SOC) 03/09/14, included a plan of care established by a physician for certification period 03/09/14 to 05/07/14 with orders for physical, occupational, and speech therapy. On 03/11/14, the patient was transferred to the hospital and returned on 03/18/14.</p> <p>a. The patient resumed services on 03/18/14 with orders for physical therapy 1 time for an evaluation then 2 times a week for 7 weeks. The physical therapist made an extra visit between the week of 03/30/14 and 04/05/14.</p> <p>b. On 04/11/14, the patient resumed services again with orders for physical therapy 1 time a week for 1 week then 2 times a week for 3 weeks and speech therapy 1 time a week for 1 week then 2 times a week for 4 weeks. The physical therapist failed to make two visits during the week of 04/27/14 to 05/03/14. Speech therapy failed to make two visits</p>		<p>organization's current policies on writing and following physician orders; making changes to the Plan of Care; documenting missed visits; and performing evaluations within 48 hours of the initiation or resumption of services. The directors of contracted services will communicate the same to all therapy staff. The nursing Supervisors, QI Coordinator, and any designated staff will audit 75% current clinical documentation for 2 months. If 90% compliance is achieved, the number of charts audited will be reduced to 50%.</p> <p>The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>between the week of 04/27/14 to 05/03/14 and 05/04/14 to 05/07/14.</p> <p>2. Clinical record number 8, SOC 06/23/14, included a plan of care established by a physician for certification period 06/23/14 to 08/21/14 with orders for occupational therapy. The occupational therapist failed to follow the plan of care within 48 hours of admission.</p> <p>3. Clinical record number 9, SOC 09/02/14, included a plan of care established by a physician for certification period 09/02/14 to 10/31/14 with orders for speech therapy. The speech therapist failed to follow the plan of care within 48 hours of admission.</p> <p>4. The Administrator, Director of Clinical Services, Therapy Director, and Clinical Supervisors were unable to provide any further documentation by the end of the exit conference on 09/26/14 at 3:45 PM.</p> <p>5. A policy titled "Contracted Services" dated 11/14/08 stated, "All contracted providers will see patients within 48 hours of receiving the referral. If the provider does not see the patient within 48 hours, the provider must call the supervisor and complete a written</p>			

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N000608	<p>communication detailing the reason for the delay ... "</p> <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: (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. Based on observation, clinical record and policy review, and interview, the agency failed to ensure the home health aide only recorded the tasks that were provided after they had been provided for 1 of 2 home health aide observations creating the potential to affect all 31 patients receiving home health aide services with the agency. (# 1)</p>	N000608	The Director of Nursing will inservice and re-instruct all Home Health Aides on proper documentation of duties performed in accordance with the care plan, including that documentation must be completed and signed by the patient only after the care is provided. Director of Nursing will inservice field staff RN's on HHA compliance with visit documentation. Field staff RN's	10/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/26/2014
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 620 RIDGE RD MUNSTER, IN 46321		
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	<p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 08/31/13, included a plan of care established by the physician for certification period 08/26/14 to 10/24/14 with orders for the home health aide to assist with bathing and ADLs (activities of daily living) 2 times a week for 9 weeks.</p> <p>a. A home visit was made to patient # 1 on 09/23/14 at 12:00 PM with Employee B, a home health aide (HHA). During the home visit, Employee B was observed to have marked the home health aide visit note with duties that were to be completed and had the patient sign the form prior to providing any duties. Duties checked off as being completed were assist with toileting, foot care, nail care, denture / oral care, shampoo (comb / brush), hair care, skin care, and lotion. The home health aide failed to perform these duties nor did she ask the patient to assist with these duties.</p> <p>b. Upon completing the visit, Employee S, Quality Assurance, indicated the home health aide should not have pre-marked the duties and should have asked the patient if he / she wanted the tasks completed.</p>		will verify compliance during supervisory visits. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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	2. An undated policy titled "Home Health Aide Competency Evaluation" stated, "Written patient care instructions will be prepared by the RN or therapy case manager, and a copy will be left in the patient chart. HHAs [home health aides] must follow the careplan on every visit; any deviation must be noted on the chart with an explanation i.e. [example] patient refused and the case manager should be notified ... "				