

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/02/2012
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NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN 46017
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G0000	<p>This was a federal home health recertification survey that resulted in an extended survey.</p> <p>Survey Dates: October 29, 30, and 31 and November 1 and 2, 2012</p> <p>Facility #: 004091</p> <p>Medicaid Vendor #: 200806840</p> <p>Surveyors: Bridget Boston, RN, PHNS, Team Leader</p> <p style="padding-left: 40px;">Susan E. Sparks, RN, PHNS, Team Member</p> <p>Census by Service Type (Unduplicated Last 12 Months)</p> <p>Skilled Patients 34 Home Health Aide Only Patients 20 Personal Service Only Patients 2 Total Patients 85</p> <p>CJ's Abundant Care is precluded from providing a home health aide training and competency evaluation program beginning November 9, 2012, through November 9, 2014, for being found out of compliance with the Conditions of Participation 484.12: Compliance with Federal, state and local laws and 484.30:</p>	G0000		

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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	<p>Skilled Nursing Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>November 9, 2012</p>			

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G0117	<p><b>484.12</b> <b>COMPLIANCE W/ FED, STATE, LOCAL LAWS</b></p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, it was determined the agency failed to ensure the Alternate Director of Nursing management change had been reported to the ISDH in 1 of 1 agency with the potential to affect all the patients of the agency (See G 120) and failed to ensure the staff followed professional standards for care during transfers of dependent individuals for 3 of 5 home health aide observation visits and followed standard infection control practices for 2 of 5 home health aide visits observed resulting in the potential for patient harm and the potential to affect all current 33 patients (See G 121).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide safe patient care and meet the requirements of the Condition of Participation 484.12: Compliance with Federal, state, and local laws.</p>	G0117	<p>G0117- The Agency notified the ISDH of the previous DON no longer working for the agency on October 18,2012. The Agency replaced the previous Director of Nursing/Alernate Administrator and submitted all required documents to the ISDH. ISDH responded on October 22, 2012 with a letter approving the new Director of Nursing/Alternate Administrator. The Alternate Director of Nursing position remains an open position. (The individual hired for this position had only worked a couple of days in the office and it was determined this individual did not have the experience or credentials for the position of the Alternate Director of Nursing.) The Administrator is responsible for ensuring on-going compliance with this requirement. CJ'S Abundant Care will ensure all staff follows professional standards of care during transfers of dependent individuals. All Home Health Aides are being retrained and competency tested on transfer techniques. This in-service and competency is scheduled for 11/19/2012. The agency will evaluate staff compliance through weekly random employee supervisory visits. Employees observed not following standards of practice with patient transfers</p>	11/20/2012	

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			<p>will have to go through further retraining and competency testing before being allowed to continue to provide care in the patient home environment. The administrator is responsible for ensuring on-going compliance with this requirement. CJ'S Abundant Care will ensure all staff follows standard infection control practices. All field employees will be in-serviced and competency tested on hand washing, use of paper towels, and hand sanitizer. This in-service and competency was completed on all field staff by 11/11/2012. The Agency will evaluate staff compliance through unannounced random employee supervisory visits. The Administrator and Director of Nursing are responsible for ensuring on-going compliance with this requirement.</p>	

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G0120	<p><b>484.12(b)</b> <b>DISCLOSURE OF OWNERSHIP &amp; MANAGEMENT</b> The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management:</p> <p>(1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter.</p> <p>(2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter.</p> <p>(3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation, association, or other company responsible for the management of the HHA.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the Alternate Director of Nursing management change had been reported to the ISDH in 1 of 1 agency with the potential to affect all the patients of the agency. (K)</p> <p>Findings:</p>	G0120	G0120- The Agency is still in the process of hiring an individual for the Alternate Director of Nursing position. The Agency continues to Advertise in the newspaper and with flyers in multiple locations in the community for this position. The agency will immediately notify ISDH with the required documents when the Alterate Director of Nursing position is filled with an appropriate candidate. The Administrator is responsible for	11/20/2012			

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	<p>1. On 10/29/2012 at 12:15 PM, the Administrator, Employee A, indicated they had hired a new Alternate Director of Nursing, employee K, and she was in training. The Administrator indicated the state had been notified.</p> <p>2. On 11/05/2012 at 12:30 PM, a request was sent to the ISDH for verification of the notification of change in the Alternate Director of Nursing. On 11/05/2012 at 12:45 PM, the ISDH informed the surveyor via email the agency had not informed the state of a change in the management at the Alternate Director of Nursing position.</p>		ensuring compliance with this requirement.		

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G0121	<p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> 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, policy review, agency document review, and interview, the agency failed to ensure the staff followed professional standards for care during transfers of dependent individuals for 3 of 5 (2, 5, and 7) home health aide observation visits and followed standard infection control practices for 2 of 5 (5 and 7) home health aide visits observed resulting in the potential for patient harm and the potential to affect all current 33 patients.</p> <p>Findings:</p> <p>Regarding the professional standards of practice:</p> <p>1. On 10/30/12 at 9:35 AM, employee E was observed to assist patient # 2 to transfer between surfaces twice without the aide of a gait belt or other adaptive equipment to support and stabilize the patient during the transfer. Additionally, the aide did not position herself in relationship to the patient to promote and allow physical support and stabilization of the patient in the event the patient lost</p>	G0121	G0121- The Agency will ensure all staff complies with professional standards of care during transfers of dependent individuals. All Home Health Aides have been retrained and competency tested on transfer techniques. This in-service and competency was completed on 11/19/2012. The agency will evaluate staff compliance through weekly random employee supervisory visits. Employees observed not following standards of practice with patient transfers will have to go through further retraining and competency testing before allowed to continue to provide care in the patient home environment. The Administrator and the Director of Nursing are responsible for ensuring on-going compliance with this requirement. The Agency will ensure staff follows standard infection control practices. All field employees were in-serviced and competency tested on hand washing, use of paper towels, and hand sanitizer. This in-service and competency was completed by 11/11/2012. The agency has provided all field staff with liquid sanitizer and paper towels. The Agency will evaluate	12/01/2012	

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	<p>balance during the transfer.</p> <p>A. During the first transfer observed, the patient was seated in a lounge chair and the aide placed a wheelchair at the foot and at 90 degrees to the left of the lounge chair. When the patient began to rise from the lounge chair, the aide stood between the lounge chair and the wheelchair, on the left of the lounge chair and the right of the wheelchair, between the two items and had no control over the transfer if the patient had fallen to the right. The aide placed her hands under the patient's arms from behind, while standing to the left of the lounge chair. The patient was not able to clear the right arm rest of the wheelchair and the aide offered no physical assistance. The patient brushed buttocks over the side arm of the wheelchair until over the seat of the chair. The patient did not lift self over the side arm of the wheelchair.</p> <p>B. During the second transfer observed, the aide placed the patient, while seated in a wheelchair, directly in front of a bedside commode. The patient was then transferred between the two surfaces, turning 180 degrees with a pivot transfer. During the transfer, the aide did not use a gait belt or other adaptive equipment to stabilize the patient. There</p>		<p>staff compliance through random employee supervisory visits. The Administrator and Director of Nursing are responsible for ensuring on-going compliance with this requirement. All home health aides were in-serviced and competency tested on correct use of adaptive devices including gait belt, cane, quad cane, wheelchair, rolling walker, tub transfer bench, and transfer board on 11/1/2012. In the event the Agency receives a patient referral for service and the patient has an adaptive device that is not on the list of devices the home health aides have received training and competency testing of; and is not on their original home health aide competency test performed at the time of hire; the Agency will individually train and competency test the home health aide on the device prior to allowing the home health aide to function independently in the patient's home. An incident report was completed on patient #5. Employee "C" was placed on probation on 10/30/2012 related to her failure to report the nonfunctioning adaptive device in the home setting. Employee "A" received a written counseling for failure to perform a follow-up assessment of patient #5 who "slipped" while in the bathroom. A gait belt will be recommended to all patients requiring transfer assist. The RN Case Manager will explain the benefits of use</p>				

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	<p>were no grab bars available and the aide placed her hands under the patients arms, from behind the patient, while the patient transferred from the wheelchair to the bedside commode.</p> <p>C. The patient indicated another aide, employee D, assisted with transfers differently. The patient indicated employee D provided care in the evenings and prepared the patient for the night. Employee D physically picked up the patient. The patient placed her / his hands just below the ribs and above the hips to indicate where employee D placed his hands and said, "It hurts" when he / she was transferred in this manner. The patient indicated employee D feared the patient would fall during transfers and did not want the patient to participate.</p> <p>D. During a review of the clinical record on 11/2/12 at 8:54 AM, employee A indicated a gait belt was added to the aide assignment sheet on 10/30/12 after the problem was identified during the home visit. She further indicated the agency did not issue a gait belt to the aide to use or to the patient to be kept in the house for all aides to use during patient transfers and stated, "She [the aide] would just have to grab her if she started to fall." Employee B confirmed the observation of employee E on 10/30/12 and indicated the</p>		<p>and potential risks and consequences for the patient refusing the use of gait belts. The Nurse will assess all patient homes for appropriate adaptive devices and home modifications that facilitate patient safety. The patient/caregivers will be notified of these safety recommendations and provided information regarding the potential risks and consequences of failing to use the adaptive device or making the home modification(i.e., grab bars). The assessment and recommendations will be documented in the clinical record. Safety Assessment of all patients homes will be completed by 12/1/2012. The Agency will evaluate staff compliance through weekly random employee supervisory visits. Employees observed not following standards of practice with patient transfers will have to go through further retraining and competency testing before being allowed to care for individuals requiring the use of adaptive devices. The Administrator and Director of Nursing are responsible for ensuring on-going compliance with this requirement.</p>		

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	<p>employee did not properly position herself when transferring the patient from the lounge chair and a gait belt was not used.</p> <p>2. On 10/30/12 at 1:30 PM, employee C was observed to cue patient #5 to ambulate approximately 20 feet from the living room, through a bedroom, and into a full bathroom, while propelling a four wheeled walker (4 WW). Employee C did not remind, cue, or instruct the patient or engage the brakes on the 4WW and the employee did not engage the brakes of the walker herself prior to requesting the patient to rise from a seated position. After the patient and aide reached their destination in the bathroom, the aide did not engage the brakes on the walker and did not cue the patient to do so. After the patient showered, the patient was sitting on the seat of the 4 WW in the bathroom. The aide instructed the patient it was time to brush his / her teeth. The patient was not wearing any footwear. The aide placed a folded towel on the floor at an angle to the sink and counter; the right 2 corners of the towel were nearest the left side of the sink. While the patient was seated on the attached seat of the 4 WW, the aide pulled the patient towards the sink and placed the patient at the same angle to the sink as the towel on the floor; the right side of the 4WW was against the</p>			
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	<p>sink and counter. The aide assisted the patient to rise from the seated position and instructed the patient to stand on the towel folded on the floor. This placed the patient standing, left of center of the sink, on top of a folded towel, without footwear, attempting to brush his / her dentures and teeth and spit into the sink / bowl which was to the patient's right. Without notice, the patient lost balance and fell backwards, buttocks falling below the seat of the 4WW. The walker was not locked and traveled away from the aide and patient, until the left wheel hit a cabinet along the bathroom wall. The aide grabbed the patient's right arm and lifted the patient up and onto the seat of the 4 WW. After the patient lost balance, the handles of the 4 WW were observed to rotate freely, only stopped by the brake cables attached and the brakes were not working on the 4WW. Neither the aide nor the patient had attempted to engage the brakes of the 4 WW throughout the observation. Employee C indicated the handles of the walker were missing screws for about a week and she was not aware the brakes were not working.</p> <p>3. On 10/31/12 at 10:10 AM, employee J was observed transferring patient #7 from a wheelchair and onto a shower bench which sat inside a regular size bathtub</p>						

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	<p>located to the patient's right side. The shower / tub did not have any grab bars and the aide did not use a gait belt during the transfer or any other transfer - safety device. The patient's right arm was flaccid and the aide held onto the right arm during the transfers in and out of the tub. The patient required hands - on maximum assistance of the aide to be repositioned on the shower bench, lifting the patient's right leg completely. The patient was stood / placed by the aide onto a clay / ceramic tile floor without placing footwear on the patient. After the patient was transferred into the tub, the patient's right leg began to tremor and the patient complained of pain related to the tremor. There was only one grab bar in the bathroom and it was located near the commode on the patient's left and functional side.</p> <p>4. On October 31, 2012, at 9:30 AM, the Administrator, Employee B, presented documentation that Employee C had been in-serviced on reporting equipment that was broken in the home.</p> <p>5. On October 31, 2012, at 3:45 PM, the Director of Nursing, Employee A, indicated Employee C had not notified the office about the broken walker in the home of patient 5.</p>						

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	<p>6. A undated policy titled "Incident Reporting", S-340, states, "Special Instructions 1. Staff members will immediately report the incident to their supervisor. An Incident Report form shall be completed in its entirety. ... 8. Incidents to be reported include, but are not limited, to: ... f. Equipment/medical device failure or malfunction"</p> <p>7. On October 31, 2012, at 3:45 PM, the Director of Nursing, Employee A, indicated Employee C had not been in-serviced on proper use of the wheeled walker and the Indiana State Department of Health couldn't possibly expect the agency to in-service the aides on every piece of equipment.</p> <p>Regarding infection control:</p> <p>1. On 10/30/12 at 1:30 PM, during a home visit observation to patient #5, employee C indicated she does not have access to disposable towel in the patient's home and did not have hand sanitizer with her. She indicated after completing hand washing, she dries her hands on the patient's cloth towel that hangs on the towel rack and was used all day.</p> <p>2. During a home visit to the home of patient # 7, on 10/31/12 at 10:10 AM, employee J was observed to dry her hands</p>						

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	<p>on a cloth towel hanging in the shared household bathroom. She indicated she used the towel all day long while working in the home. The towel was draped over a wooden hook in the bathroom and the bottom tip of the towel was approximately one inch above a pile of clothing.</p> <p>3. The undated policy titled "Infection Prevention / Control" number B-403 stated, "CJ's Abundant Care will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC)."</p> <p>4. The Centers for Disease Control "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, " IV. Standard Precautions . . . IV.A. Hand Hygiene. 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 . . . IV.A.3. Perform hand hygiene: . . . IV.A.3.b. After contact with excretions, mucous membranes, . . . IV.A.3.d. If hands will be moving from a contaminated body site to a clean body site during patient care."</p>			

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	5. The undated policy titled "Standards of practice" stated, "CJ's Abundant Care will provide services that are in compliance with acceptable professional standards for the Home Care industry as well as all state and federal laws and identified agency performance improvement standards."				

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G0139	<p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE</p> <p>Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the new Alternate Director of Nursing was qualified in 1 of 1 management changes with the potential to effect all 33 patients. (K)</p> <p>Findings:</p> <p>1. On 10/29/2012 at 12:15 PM, the Administrator, Employee A, indicated they had hired a new Alternate Director of Nursing, employee K, and she was in training. The Administrator indicated the state had been notified.</p> <p>On 10/29/2012 at 2:00 PM, the personnel file of the new Alternate Director of Nursing was requested and presented to the surveyors. The resume was scanned and sent to the ISDH on 11/5/12 at 12: 30 PM.</p>	G0139	G-0139 The Agency is still in process of hiring an individual for the Alternate Director of Nursing position. The Agency continues to advertise in the newspaper and with flyers in multiple locations in the community. The Agency will immediately notify the ISDH with the required documents when the Alternate Director of Nursing position is filled with and appropriate candidate. The Administrator is responsible for ensuring compliance with this requirement.	11/20/2012			

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	<p>2. On 11/05/2012 at 12:30 PM, a request was sent to the ISDH for verification of the notification of change in the Alternate Director of Nursing.</p> <p>3. On 11/05/2012 at 12:45 PM, the ISDH informed the surveyor via email the agency had not informed the state of a change in the management at the Alternate Director of Nursing position. The email also identified the nurse hired to be The Alternate Director of Nurse was not qualified to be a Alternate Director of Nursing due to a lack of supervisory experience.</p>			

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the care provided followed a physician ordered plan of care in 6 of 10 clinical records reviewed creating the potential for treatment omission and patient harm and affect all the patients of the agency. (1, 4, 6, 8, 9, and 10)</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care 8/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 8/24/12 through 10/22/12. The plan of care was three pages in total and at the top of the 3 pages stated, "Sep - 05-2012 (WED) 12:49." The record evidenced a facsimile face sheet attached to the plan of care dated 9/5/12 that stated, "Dr [Name] ... Please sign / date and fax back," 13 days after the start of care. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p>	G0158	<p>G-0158 CJ'S Abundant Care ensures that all patient care is provided as directed by a physician. The Admission Process includes the following changes: a. At time of acceptance of a patient referral, the Skilled Nurse will obtain a verbal order from the Physician to "assess and evaluate" the patient for appropriateness for home health care services. The verbal order to assess and evaluate the patient will be documented on a Physician Order Form containing the services needed and the specific type of treatment/care to be provided upon SOC. b. Immediately following the comprehensive assessment the Registered Nurse contacts the physician with his/her assessment findings. The Physician and Registered Nurse collaborate on the development of the Plan of Care.</p> <p>a. The documentation of this physician contact will be located on a Clinical Addendum for attached to the Comprehensive Assessment. b. This documentation will contain the following: i. Dr. _____, has been notified of the</p>	11/20/2012	

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	<p>On 11/2/12 at 8:54 AM, employee A indicated the plan of care was the verbal order.</p> <p>2. Clinical record 4, start of care 10/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 10/24/12 through 12/22/12 with orders for home health aide services only 3-5 hours per day, 4-5 times a week through out the certification period. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>A. During a home visit on 10/30/12 at 11 AM, the patient indicated home health aide services began on 10/25/12.</p> <p>B. On 11/2/12 at 8:54 AM, employee A indicated the plan of care was the verbal order for admission for home health services.</p> <p>3. Clinical record # 6, start of care 6/5/09, evidenced a recertification comprehensive assessment dated 10/3/12 that identified the patient was at risk of falls. The attending physician ordered</p>		<p>assessment findings on _____ at _____.</p> <p>ii. Communication of the assessment findings. (Clinical Addendum) iii. The services to be provided including disciplines, frequency of services, and type of services to be provided. iv. A verbal order will be obtained and documented on a physician verbal order form containing disciplines, frequency of services, and type of treatment/services to be provided. c. The detailed physician orders resulting from this discussion are documented on the Plan of Care(485) document The orders include the following: i. The patient's diagnoses ii. A listing of the patient's medications including dosage and frequency of administration. iii. The disciplines ordered iv. The services to be provided v. The frequency and duration of the services vi. The specific tasks each discipline is to provide vii. Identification of any hi risk parameters for notifying the physician such as following: 1. Vital Signs Parameters 2. PT/INR Parameters for patients on anticoagulant therapy 3. Blood sugar parameters for diabetic patients viii. The goals of the care to be provided d. The information as documented on the "Clinical Addendum" is repeated in the Plan of Care (485) at the bottom of Locator 21, including the date and time of</p>		

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	<p>physical therapy, occupational therapy, speech therapy, and wound care on 10/5/12. The record failed to evidence the patient received the ordered services. The record failed to evidence a physician order to discontinue the ordered therapy services.</p> <p>On 11/2/12 at 8:54 AM, employee A indicated the record did not evidence therapy services had been provided. She indicated she notified the physician the patient declined the ordered services.</p> <p>4. Clinical record 8, start of care 5/15/11, included a plan of care for the certification period 9/6/12 through 11/4/12. The record evidenced a skilled nurse visit note dated 8/3/12 documented by employee A that stated, "U/A C &amp; S per I &amp; O cath." The record failed to evidence a physician order to collect a urine sample via an catheter.</p> <p>On 11/2/12 at 10:30 AM, employee A was asked if there was a physician order for the use of a catheter to collect urine sample. Employee A indicated she only wrote on the nurses note and the record does not evidence a written physician order.</p> <p>5. Clinical record 9, start of care 8/15/12 evidenced a comprehensive assessment</p>		<p>physician contact and the Admission Summary of the assessment findings. e. The Admission Summary provides validation of the collaboration in the development of the plan of care between the Physician, Registered Nurse, and Patient/Caregiver. The Summary also includes the summation of the assessment findings, patient condition, and need for services. f. In Addition: Locator #23 of the Plan of Care (485) is the box designated for th RN to indicate when she/he obtained physician orders for the "verbal start of care" by documenting the RN signature and date she/he received the verbal orders to initiate services for the Plan of Care. g.. The Physician's signature of the document (Plan of Care/485) is a confirmation that the discussion took place and an authorization of the physician orders as written. Registered Nurse Case Managers will be re-educated on this process and their responsibilities to obtain physician orders for the development of the Plan of Care and all additional supplemental physician orders as patient needs change through-out the 60 day episode of care (Date: 12/12/2012) The Agency will ensure on-going compliance with this requirement. The Agency will audit 100% of all clinical records at start-of-care,</p>				

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	<p>dated 8/15/12 and a plan of care dated 8/15/12 through 10/13/12. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>On 11/2/12 at 10:35 AM, employee A indicated the plan of care was the verbal order and admission to home care.</p> <p>6. Clinical record 10, start of care 9/5/12, evidenced a comprehensive assessment dated 9/5/12 and a plan of care dated 9/5/12 through 11/3/12. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>On 11/2/12 at 10:35 AM, employee A indicated the plan of care was the verbal order and admission to home care.</p> <p>7. The policy titled "Plan of Care" dated 2/14/12 stated, "An individualized Plan of Care signed by the physician shall be required for each client receiving home</p>		<p>resumption-of-care, recertification, transfer, and discharge to ensure the clinician has obtained and documented physician orders for the provision of care. The Administrator is responsible for ensuring compliance with this requirement. See Attachments</p>				

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	health and personal care services. The plan of care shall be completed in full to include: ... Any safety Measures to protect against injury, Instructions to client / caregiver."			

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G0159	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, interview, and clinical record and policy review, the agency failed to ensure all patients had an individualized plan of care that included specific fall prevention interventions in 7 (# 1, 2, 3, 4, 5, 7, and 9 ) of 10 clinical records reviewed creating the potential for treatment omission and patient harm and affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record 1, start of care (SOC) 8/24/12, evidenced a plan of care (POC) dated 8/24/12 through 10/22/12 with orders for a home health aide 4 - 6 hours per day 5- 7 days a week throughout the certification period to assist with ambulation and mobility and a skilled nurse visit once a month for "Assess / instruct on home safety management / falls preventions." The POC stated, "Initial Summary ... Client also has pain in her legs / feet ... client's pain is all the</p>	G0159	G0159- The Agency will address patient safety in Physician Plan of Care under Locator #15, and #21. These sections address each patient's specific safety needs based on each patient's "patient specific" comprehensive assessment. Locator #21 will also include Home Safety directions specific to each patient. CJ'S Abundant Care utilizes the following screens to identify each patient's safety and fall risks: a Fall Risk Assessment in the Comprehensive Assessment Tool b. Timed Up and Go Test c. Risk of Hospitalization Screens The Agency has held training and competency testing for the home health aides on use of adaptive devices and patient transfer procedures. (11/01/2012) The Agency has conducted additional home health aide training and competency testing on " patient transfer techniques" on 11/19/12. The Home Health Aide Care Plan will be individualized to meet each patient's personal care and safety	12/01/2012			

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	<p>time and is worst with ambulation and better with rest, ... Client is SOB [short of breath] with moderate exertion. ... Client uses a rolling walker for ambulation, has steady gait with rolling walker but has poor endurance. .... Client is in need of a home health aide for ADL's [activities of daily living] I.E.: Bathing, dressing, grooming, ... due to her chronic pain, SOB, and muscle weakness. ... Safety Measures: ... Fall Precautions ... Goals: ... Client will demonstrate safe functional ambulation with assistive device." The plan of care failed to evidence specific fall prevention interventions for the staff to implement while providing care to this patient that addressed the identified risks of fall.</p> <p>2. Clinical record 2, SOC 4/23/12, evidenced a plan of care dated 10/21/12 through 12/19/12 that included orders for home health aide 1 - 3 hours, 1 - 3 times a day, 6 - 7 days a week throughout the certification period to assist with ambulation and mobility. The POC stated, "Safety Measures: ... Fall Precautions ... lock w/c [wheelchair] with transfers ... Goals: ... Client will demonstrate safe functional ambulation with walker / wheelchair mobility." The record included three documents titled "Aide Care Plan" dated 10/15/12 for 3 specific shifts, first, second, and third.</p>		<p>needs. Personal Care Guidelines and Fall Prevention Guidelines will be attached to the Home Health Aide Plan of Care to provide specific individualized guidance. This document will be reviewed every 60 days or whenever there is a significant change-in-condition and updated as needed to meet the patient's needs. All Home Health Aide Care Plans will be updated with the guidelines by 12/1/2012 Patient's #1, 2, 3, 4, 5, 7, &amp; 9 will receive additional home safety assessments and education specific to their needs by 11/19/2012. The Agency will ensure on-going compliance with patient safety through clinical record audits, home health aide supervisory visits, and weekly random supervisory visits. The Administrator and Director of Nursing are responsible for ensuring compliance with this requirement. The Agency will ensure on-going compliance with patient safety through clinical record audits at Start-of-Care, Recertification,/Resumption and whenever there is a significant-change-in-condition. In addition patient safety will be reviewed at the home health aide supervisory visits, and random administrative supervisory visits. The Administrator and Director of Nursing are responsible for ensuring compliance with this requirement.</p>		

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	<p>The plan of care failed to evidence specific fall prevention interventions for the staff to implement while providing care to this patient that addressed the identified risks of fall.</p> <p>3. Clinical record 3, SOC 4/11/12, evidenced a plan of care dated 10/8/12 through 12/6/12 with the diagnosis of Legal Blindness and orders for a home health aide 3-4 hours a day, 4-5 times a week for 9 weeks. The plan of care failed to specify the specific intervention the aide was to follow while rendering care to the patient to prevent falls.</p> <p>4. Clinical record 4, start of care 10/24/12, evidenced a plan of care dated 10/24/12 through 12/22/12 and orders for home health aide services only 3-5 hours per day, 4-5 times a week through out the certification period, Safety Measures: Fall precautions, and diagnosis Seizures. The plan of care failed to evidence the specific interventions for the aide to follow to prevent falls.</p> <p>On 10/30/12 at 11 AM, the patient indicated seizure activity occurred every day.</p> <p>5. Clinical record 5, start of care 12/7/10, included a plan of care for the certification period 9/27/12 through</p>				

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	<p>11/25/12 with orders for aide only services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific interventions for the aide to follow to prevent falls.</p> <p>6. Clinical record 7, start of care 6/8/07, evidenced a sixty day summary dated 9/7/12 that stated, "The client can stand for short period to pivot with transfers, but becomes SOB [short of breath] with minimal exertion. The clients right side is almost flaccid, has minimal use of right arm / right leg."</p> <p>The record evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation, and mobility. The plan of care failed to</p>						

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	<p>evidence the specific interventions for the staff to follow to prevent falls, related to the patient's identified risk factors.</p> <p>7. Clinical record 9, start of care 8/15/12, evidenced a comprehensive assessment dated 8/15/12 and a fall risk was assessed to be 50 that stated, "Educated on methods of reducing fall risk ... client v/u [verbalized understanding]; however, needs reinforcement."</p> <p>The record evidenced a plan of care dated 8/15/12 through 10/13/12 with Safety Measures identified as Fall Precautions. The Plan of care failed to evidence the specific interventions for the staff to follow to prevent falls.</p> <p>8. The policy titled "Plan of Care" dated 2/14/12 stated, "An individualized Plan of Care signed by the physician shall be required for each client receiving home health and personal care services. The plan of care shall be completed in full to include: ... Any safety Measures to protect against injury, Instructions to client / caregiver."</p>				

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G0168	<p><b>484.30 SKILLED NURSING SERVICES</b></p> <p>Based on a home visit observation, clinical record and policy review, and interview, it was determined the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 1 of 10 records reviewed with the potential to affect all the patients receiving skilled nursing services from the agency (See G 170); failed to ensure the registered nurse re-evaluated the patients' needs after an identified unsafe incident or change in environment in 2 of 5 aide home visit observations with the potential to affect all patients (See G 172); failed to ensure the registered nurse initiated appropriate preventative and rehabilitative procedures for the patient risks identified on the comprehensive assessment in 8 of 10 clinical records reviewed of patients with orders for home health aide services, creating the potential for treatment omission and patient harm for all the patients of the agency (See G 175); and failed to ensure the registered nurse counseled the family to meet the identified needs in 1 of 5 clinical records reviewed of patients with aide observation creating the potential for treatment omission and patient harm for all the patients of the agency(See G 177).</p> <p>The cumulative effect of these systemic</p>	G0168	G-0168 The Agency has completed a disciplinary action with the Registered Nurse (employee A) who failed to re-evaluate the patient's safety needs. In addition the RN has been provided additional guidance on her responsibilities for patient safety in the home setting. The Administrator will ensure on-going compliance through home observations of the RN providing patient care, tracking of patient falls with the PI program, and clinical record audits (all clinical records are audited at time of admission, recertificaton, resumption of care, transfer, and discharge). 10% of all clinical records are reviewed quarterly. The Administrator is responsible for ensuring compliance with this requirement.	11/19/2012			

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	problems resulted in the agency's inability to provide safe and preventative skilled care and meet the requirements of the Condition of Participation 484.30: Skilled Nursing Services.			

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G0170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 1 of 10 records reviewed (#8) with the potential to affect all the patients receiving skilled nursing services from the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 8, start of care 5/15/11, included a plan of care for the certification period 9/6/12 through 11/4/12. The record evidenced a skilled nurse visit note dated 8/3/12 documented by employee A, registered nurse, that stated, "U/A C &amp; S per I &amp; O cath." The record failed to evidence a physician order to collect a urine sample via an catheter.</li> <li>On 11/2/12 at 10:30 AM, employee A was asked if there was a physician order for the use of a catheter to collect urine sample. Employee A indicated she only wrote on the nurses note and the record does not evidence a written physician order.</li> </ol>			G0170	<p>G-0170 The Agency will ensure all patient care is provided per physician orders. The skilled Nurse (employee A) has received a disciplinary action and counseled on the necessity for physician orders for all treatments and procedures on 11/14/2012 The Administrator will ensure on-going compliance through clinical record audits ( all clinical records are audited at time of admission, recertification, resumption of care, transfer, and discharge and 10% of all clinical records are reviewed quarterly.) The Administrator is responsible for ensuring compliance with this requirement.</p>		11/19/2012

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G0172	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse regularly re-evaluates the patients nursing needs. Based on a home visit observation, clinical record and policy review, and interview, the agency failed to ensure the registered nurse re-evaluated the patients' needs after an identified unsafe incident or change in environment in 2 (5 and 7) of 5 aide home visit observations with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record 5, start of care 12/7/10 included a plan of care for the certification period 9/27/12 through 11/25/12 with orders for aide services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific individualized interventions implemented for this patient to prevent falls.</p> <p>A. The record evidenced an Aide</p>	G0172	G-0172 The Agency will ensure all patients are regularly re-evaluated following any incident regarding patient safety, with any health concern, or environmental change. The Skilled Nurse(employee A) has received a disciplinary action and counseled regarding her failure to re-evaluate the patient following the incident and provided education regarding her responsibilities to re-evaluate all patients following any safety and/or health incidents in the home and when the patient changes his/her place of residence 11/14/2012. The Skilled Nurse( employee A) has been re-educated on the assessment, education, and reporting responsibilities of the RN Case Manager on 11/14/2012. Home Health Aide Care Plans will include the document "Guidelines for Safety in Personal Care and Fall Prevention. Each Patient will have their own individualized guideline that will be given to the home health aide. The home health aides will receive instruction on these guidelines and there will be a copy of the guideline in every home folder of patient's receiving home health aide services. The Home Health Aide Care Plan and Guideline will	12/01/2012			

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	<p>Care Plan dated 6/11/12, 7/23/12, 8/23/12, and 9/24/12 that stated, "Patient problem: Alzheimer ... hx [history] of falls ... Precautionary and other pertinent information ... Lives alone ...up as tolerated ... fall precautions ... forgetful." The Aide Care Plan failed to specify the specific fall precautions and strategies for the aide to follow while rendering care for this patient.</p> <p>B. On 10/30/12 at 1:30 PM, employee C was observed to cue the patient to ambulate approximately 20 feet from the living room, through a bedroom, and into a full bathroom, while propelling a four wheeled walker (4 WW). Employee C did not remind, cue, or instruct the patient or engage the brakes on the 4WW and the employee did not engage the brakes of the walker herself prior to requesting the patient to rise from a seated position. After the patient and aide reached their destination in the bathroom, the aide did not engage the brakes on the walker and did not cue the patient to engage the brakes. After the patient showered, the patient was sitting on the seat of the 4 WW in the bathroom. The aide instructed the patient that it was time to brush his / her teeth. The patient was not wearing any footwear. The aide placed a folded towel on the floor at an angle to the sink and counter; the right 2</p>		<p>be updated with any patient change-in-condition and reviewed at least every 60 days. All Home Health Aide Care Plans will be updated by 12/1/2012 Patients #5 and #7 have been re-evaluated and their clinical records evidence documentation of the assessment, the physician has been notified if any provision of care changes were needed, and the home health aide care plan was reviewed and updated if needed. The Administrator will ensure on-going compliance through home observations of the RN providing patient care, tracking patient falls with the PI program, and clinical record audits(all clinical records are audited at the time of admission, recertification, resumption of care, transfer, and discharge.) 10% of all clinical records are reviewed quarterly. The Administrator is responsible for ensuring compliance with this requirement.</p>		

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	<p>corners of the towel were nearest the left side of the sink. While the patient was seated on the attached seat of the 4 WW, the aide pulled the patient towards the sink and placed the patient at the same angle to the sink as the towel on the floor; the right side of the 4WW was against the sink and counter. The aide assisted the patient to rise from the seated position and instructed the patient to stand on the towel folded on the floor. This placed the patient standing left of center of the sink, on top of a folded towel, without footwear, attempting to brush his / her dentures and teeth, and spit into the sink / bowl which was to the patient's right. Without notice, the patient lost balance and fell backwards, buttocks falling below the seat of the 4WW. The walker was not locked and traveled away from the aide and patient until the left wheel hit a cabinet along the bathroom wall. The aide grabbed the patient's right arm and lifted the patient up and onto the seat of the 4 WW. After patient lost balance, the handles of the 4 WW rotated freely, only stopped by the brake cables attached and the brakes were not working on the 4WW. Neither the aide nor the patient had attempted to engage the brakes of the 4 WW throughout the observation. Employee C indicated the handles of the walker were missing screws for about a week and she was not aware the brakes</p>			

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	<p>were not working.</p> <p>C. On 11/2/12 at 8:54 AM, employee A indicated a registered nurse had not visited and evaluated the patient since the home visit of 10/30/12 at 1:30 PM in which the patient lost balance and the patient was in receipt of a new four wheeled walker.</p> <p>2. Clinical record 7, start of care 6/7/07, evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p> <p>A. The record evidenced a care coordination note dated 6/26/12 that indicated the patient's roommate, a family member, died and the patient would be moving in with another relative.</p> <p>B. The record evidenced an "Interdisciplinary Note" dated 7/10/12 that stated, "Updated address et [and] that client is no longer living alone."</p>						

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	<p>C. The record failed to evidence a nurse evaluated the patient's new environment and taught and educated the new care givers regarding safety precautions related to the patients risk of falls.</p> <p>D. On 10/31/12 at 10:10 AM, employee J was observed transferring the patient from a wheelchair and onto a shower bench which sat inside a regular size bathtub located to the patient's right side. The shower / tub did not have any grab bars and the aide did not use a gait belt during the transfer or any other transfer - safety device. The patient's right arm was flaccid and the aide held onto the right arm during both transfers in and out of the tub. The patient required hands-on maximum assistance of the aide to be repositioned on the shower bench; lifting the patient's right leg completely. The patient was stood by the aide onto a clay / ceramic tile floor without placing footwear on the patient. After the patient was transferred into the tub, the patient's right leg began to tremor and the patient complained of pain related to the tremor. There was only one grab bar in the bathroom and it was located near the commode and would be on the patient's left and functional side.</p> <p>D. On 11/2/12 at 8:54 AM, Employee</p>				

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	<p>A indicated the aide continued to provide hands on care and assistance as ordered on the plan of care after the patient moved to a new environment and home and prior to the registered nurse assessing the area for fall risks and concerns related to the provision of patient care by the home health aide. She indicated the patient 's new home and environment was not assessed until the scheduled visited on 7/29/12 and indicated she had not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p> <p>3. The undated policy titled "Skilled Nursing Services" number C-200 stated, "The registered nurse: ... regularly reevaluates the client needs. ... Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... Supervises and teaches other nursing personnel and home health aides as appropriate."</p> <p>4. On 10/30/12 at 3:45 PM, employee A indicated she did not see how the agency could possibly train the aides on every piece of equipment.</p> <p>5. On 10/31/12 at 9:40 AM, employee B</p>			

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	<p>indicated she noted an an increased number of patient falls in April 2012 and, therefore, falls in the home were addressed in the agency quality improvement program.</p> <p>6. On 11/2/12 at 8:54 AM, employees A and B indicated the agency did not have a policy and procedure to guide and patient transfers in the home when aided by the home health agency staff.</p>			

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G0175	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the registered nurse initiated appropriate preventative and rehabilitative procedures for the patient risks identified on the comprehensive assessment in 8 of 10 (1, 2, 3, 4, 5, 7, 8, and 9) clinical records reviewed of patients with orders for home health aide services, creating the potential for treatment omission and patient harm for all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 1, start of care (SOC) 8/24/12, included a comprehensive assessment dated 8/24/12 completed by employee K. The comprehensive assessment included a fall risk assessment. The assessor determined the patient had a fall risk of 40. The document stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient.</li> </ol>	G0175	G-0175 Patients 1, 2, 3, 4, 5, 7, 8, and 9 will have a reassessment of their patient risks and will be re-educated in strategies specific to their areas of risk by 11/19/2012. The RN Case Manager will inform the patients/caregivers/POAs of their areas "risk". The RN Case Manager will provide recommendations and education on the appropriate assistive device and notify the individuals if there is a need for home modification to facilitate patient safety. The RN Case Manager will inform the individuals of the advantages of utilizing the adaptive devices and potential risks and consequences to their safety if they elect to not purchase the assistive devices. The Home Health Aide Care Plans will be updated to reflect patient specific need and areas of weakness. Physician orders will be written as needed. Patients 1, 2, 3, 4, 5, 7, 8, and 9 will have safety reassessments completed by 11/19/2012. All Home Health Aide Care Plans will be updated by 12/1/2012. Home Health Aide Care Plans will include the document " Guidelines for Safety in Personal Care and Fall Prevention". Each patient will have their own individualized	12/01/2012			

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	<p>Hand written below the score of 40, it stated, " Pt. [patient] refuses any referrals for therapy."</p> <p>The record evidenced a plan of care (POC) dated 8/24/12 through 10/22/12 with orders for a home health aide 4 - 6 hours per day 5- 7 days through out the certification period to assist with ambulation and mobility and a skilled nurse visit once a month for "Assess / instruct on home safety management / falls preventions." The POC stated, "Initial Summary ... Client also has pain in her legs / feet ... client's pain is all the time and is worst with ambulation and better with rest, ... Client is SOB [short of breath] with moderate exertion. ... Client uses a rolling walker for ambulation, has steady gait with rolling walker but has poor endurance. .... Client is in need of a home health aide for ADL's [activities of daily living] I.E.: Bathing, dressing, grooming, ... due to her chronic pain, SOB, and muscle weakness. ... Safety Measures: ... Fall Precautions ... Goals: ... Client will demonstrate safe functional ambulation with assistive device." The record included a document titled "Aide Care Plan" dated 8/24/12. The POC and Aide Care Plan failed to evidence specific fall prevention interventions and instructions for the aide to follow while providing care to this</p>		<p>guideline that will be given to the home health aide. The home health aides will receive instruction on these guidelines and there will be a copy of the guideline in every home folder of patients receiving home health aide services. The Home Health Aide Care Plan and Guideline will be updated with any patient change-in-condition and reviewed at least every 60 days. All Home Health Aide Care Plans will be updated with the guidelines by 12/1/2012. The Administrator will ensure on-going compliance through home observations of the RN providing patient care, tracking of patient falls with the PI program, and clinical record audits(all clinical records are audited at time of admission, recertification, resumption of care, transfer, and discharge). 10% of all clinical records are reviewed quarterly. In addition all Home Health Aides have been retrained and competency tested on adaptive devices . (11/01/12)</p> <p>All home health aides employees are being retrained and competency tested on transfer techniques. This in-service and competency is scheduled for 11/19/2012. The Agency will evaluate field staff compliance through weekly random employee supervisory visits. Employees observed not following standards of practice with patient transfers will have to go through further retraining and</p>	

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	<p>patient that addressed the identified unsteady gait.</p> <p>2. Clinical record 2, SOC 4/23/12, included a recertification comprehensive assessment dated 10/15/12 completed by employee A. The assessment stated, "Primary diagnosis - Muscle Weakness, other diagnosis, chronic pain ... abnormality of gait ... Pain ... ongoing, location - back, duration - constant ... dyspnea with minimal exertion ... Unsteady gait has walker or w/c [wheelchair]. Fall risk assessment ... 45. ... Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient."</p> <p>A. The plan of care dated 10/21/12 through 12/19/12 included orders for home health aide 1 - 3 hours, 1 - 3 times a day, 6 - 7 days a week throughout the certification period to assist with ambulation and mobility. The POC stated, "Safety Measures: ... Fall Precautions ... lock w/c [wheelchair] with transfers ... Goals: ... Client will demonstrate safe functional ambulation with walker / wheelchair mobility." The</p>		<p>competency testing before being allowed to continue to provided care in the patient home setting. The Administrator and the Director of Nursing are responsible for ensuring on-going compliance with this requirement.</p>				

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	<p>record included three documents titled "Aide Care Plan" dated 10/15/12, one for each shift -first, second, and third. The The POC and Aide Care Plans failed to include the specific fall prevention interventions for the aide to follow while providing direct care to this patient.</p> <p>B. On 10/30/12 at 9:35 AM, employee E was observed to assist patient # 2 to transfer between surfaces twice without the aide of a gait belt or other adaptive equipment to support and stabilize the patient during the transfer. The aide did not position herself in relationship to the patient to promote and allow physical support and stabilize the patient in the event the patient lost balance during the transfer.</p> <p>C. During the first transfer observed, the patient was seated in a lounge chair and the aide placed a wheelchair at the foot and at 90 degrees to the left of the lounge chair. When the patient began to rise from the lounge chair, the aide stood between the lounge chair and the wheelchair, on the left of the lounge chair and the right of the wheelchair, between the two items. She placed her hands under the patient's arms from behind while standing to the left of the lounge chair. The patient was not able to clear the right arm rest of the</p>			

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NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN 46017
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	<p>wheelchair and the aide offered no physical assistance. The patient brushed buttocks over the side arm of the wheelchair until over the seat. The patient did not lift self over the side arm of the wheelchair.</p> <p>D. During the second transfer, the aide placed the patient, while seated in a wheelchair, directly in front of a bedside commode. The patient was then transferred between the two surfaces, turning 180 degrees, with a pivot transfer and slouched position. During the transfer, the aide did not use a gait belt or other adaptive equipment to stabilize the patient. There were no grab bars available and the aide placed her hands under the patients arms, from behind the patient, while the patient transferred from the wheelchair to the bedside commode.</p> <p>E. The patient indicated another aide, employee D, assisted with transfers differently. The patient indicated employee D provided care in the evenings and prepared the patient for the night and indicated employee D physically picked up the patient. The patient placed her / his hands just below the ribs and above the hips to indicate where employee D placed his hands and said, "It hurts" when he / she was transferred in this manor. The patient indicated employee D feared</p>			

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	<p>the patient would fall during transfers and did not want the patient to participate.</p> <p>F. On 11/2/12 at 8:54 AM, employee A indicated a gait belt was added to the aide assignment sheet on 10/30/12 after the problem was identified during the home visit. She further indicated the agency did not issue a gait belt to the aide to use or to the patient to be kept in the house for all aides to use during patient transfers and stated, "She [the aide] would just have to grab her if she started to fall." Employee B confirmed the observation of employee E on 10/30/12 and indicated the employee did not properly position herself when transferring the patient from the lounge chair and a gait belt was not used.</p> <p>3. Clinical record 3, SOC 4/11/12, included a recertification comprehensive assessment dated 10/3/12 completed by employee A. The assessment stated, "Legally Blind, other diagnosis - chronic pain, urinary incontinence, ... , malaise / fatigue, CKD [chronic kidney disease. ... Pain ... makes it difficult to complete ADL's [activities of daily living]. ... Fall risk assessment ... 45. ... Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2.</p>			

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	<p>Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient. ... Rehabilitation Potential Goals ... Aide: Client to remain safe within [his / her] home AEB [as evidenced by] 0 [no] falls +/- [throughout] cert [certification period]."</p> <p>The record evidenced a plan of care dated 10/8/12 through 12/6/12 with orders for a home health aide 3-4 hours a day, 4-5 times a week for 9 weeks. The record also evidenced Aide Care Plans dated 4/11/12, 6/9/12, 8/7/12, and 10/3/12 that evidenced fall precautions. The plan of care and aide care plans failed to specify the specific intervention the aide was to follow while rendering care to the patient to prevent falls.</p> <p>4. Clinical record 4, start of care 10/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 10/24/12 through 12/22/12 with orders for home health aide services only 3-5 hours per day, 4-5 times a week throughout the certification period. The record included an Aide Care Plan that stated, "Patient Problem: Seizures, chronic pain, ... Precautionary and other pertinent information ... Lives alone ...up as tolerated ... fall precautions ... forgetful / Confused." The aide care plan</p>						

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	<p>failed to evidence the specific interventions for the aide to follow specific for this patient.</p> <p>On 10/30/12 at 11 AM, the patient indicated seizures activity occurred every day.</p> <p>5. Clinical record 5, start of care 12/7/10, included a plan of care for the certification period 9/27/12 through 11/25/12 with orders for aide services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific individualized interventions implemented for this patient to prevent falls.</p> <p>A. The record evidenced Aide Care Plans dated 6/11/12, 7/23/12, 8/23/12, and 9/24/12 that stated, "Patient problem: Alzheimer ... hx [history] of falls ... Precautionary and other pertinent information ... Lives alone ...up as tolerated ... fall precautions ...</p>						

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	<p>forgetful." The Aide Care Plan failed to specify the specific fall precautions and strategies for the aide to follow while rendering care for this patient."</p> <p>B. On 10/30/12 at 1:30 PM, employee C was observed to cue the patient to ambulate approximately 20 feet from the living room, through a bedroom, and into a full bathroom while propelling a four wheeled walker (4 WW). Employee C did not remind, cue, or instruct the patient or engage the brakes on the 4WW and the employee did not engage the brakes of the walker herself prior to requesting the patient to rise from a seated position. After the patient and aide reached their destination in the bathroom, the aide did not engage the brakes on the walker and did not cue the patient. After the patient showered, the patient was sitting on the seat of the 4 WW in the bathroom. The aide instructed the patient it was time to brush his / her teeth. The patient was not wearing any footwear. The aide placed a folded towel on the floor at an angle to the sink and counter; the right 2 corners of the towel were nearest the left side of the sink. While the patient was seated on the attached seat of the 4 WW, the aide pulled the patient towards the sink and placed the patient at the same angle to the sink as the towel on the floor; the right</p>			

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	<p>side of the 4WW was against the sink and counter. The aide assisted the patient to rise from the seated position and instructed the patient to stand on the towel folded on the floor. This placed the patient standing, left of center of the sink, on top of a folded towel, without footwear, attempting to brush his / her dentures and teeth and spit into the sink / bowl which was to the patient's right. Without notice, the patient lost balance and fell backwards, buttocks falling below the seat of the 4WW. The walker was not locked and traveled away from the aide and patient until the left wheel hit a cabinet along the bathroom wall. The aide grabbed the patient's right arm and lifted the patient up and onto the seat of the 4 WW. After the patient lost balance, the handles of the 4 WW rotated freely, only stopped by the brake cables attached and the brakes were not working on the 4WW. Neither the aide nor the patient had attempted to engage the brakes of the 4 WW throughout the observation. Employee C indicated the handles of the walker were missing screws for about a week and she was not aware the brakes were not working.</p> <p>C. At 2 PM, employee C indicated she was not aware she needed to inform the agency and nurses of defective equipment left in the home.</p>						

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	<p>D. During the home visit, employee B, the administrator, and C, the aide, were unable to find a current aide assignment or aide care plan in the home. Employee B indicated the most recent assignment sheet found in the home was dated 5/26/11. Employee C indicated she received an assignment sheet a few months earlier to take home. She indicated she did not have a current assignment sheet in the home for the aide care delivered on 10/30/12.</p> <p>6. Clinical record 7, start of care 6/8/07, evidenced a recertification comprehensive assessment dated 9/7/12 that stated, "Primary Diagnosis hemiplegia ... other diagnoses ... chronic pain, right hand contracture [sp]. ... Fall risk assessment ... 40. ... Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient." A sixty day summary dated 9/7/12 stated, "The client can stand for short period to pivot with transfers, but becomes SOB [short of breath] with minimal exertion. The clients right side is almost flaccid, has minimal use of right arm / right leg."</p>						

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	<p>A. The record evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 and orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p> <p>B. The record evidenced documents titled "Aide Care Plan" dated 6/25/12, 7/10/12, 8/7/12, and 9/7/12 that failed to evidence specific interventions implemented and directions for the aide related to this patient's abilities and risk of falls while providing patient assistance in the home.</p> <p>C. On 10/31/12 at 10:10 AM, employee J was observed transferring the patient from a wheelchair and onto a shower bench which sat inside a regular size bathtub located to the patient's right side. The shower / tub did not have any grab bars and the aide did not use a gait belt during the transfer or any other transfer - safety device. The patient's right arm was flaccid and the aide held onto the right arm during both transfers in</p>						

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	<p>and out of the tub. The patient required hands-on maximum assistance of the aide to be repositioned on the shower bench; lifting the patient's right leg completely. The patient was stood by the aide onto a clay / ceramic tile floor without placing footwear on the patient. After the patient was transferred into the tub, the patient's right leg began to tremor and the patient complained of pain related to the tremor. There was only one grab bar in the bathroom and it was located near the commode and would be on the patient's left and functional side.</p> <p>D. On 11/2/12 at 8:54 AM, employee A indicated she has not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p> <p>7. Clinical record 8, start of care 5/15/11, evidenced a recertification comprehensive assessment dated 9/4/12 documented by employee A that included a fall risk score of 30 that stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient. ... Client / CG [caregiver] instructed on</p>						

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	<p>methods of reducing fall risk: keep pathways clear, wear shoes that fit well, use night light, secure loose rugs, client / CG V/U [verbalized understanding]. Assessment for recertification completed. Client / CG continue wishes to remain a DNR. Order in place. Reviewed when to call agency vs [verse] MD vs 911. CG V/U. ... Client is not oriented, cannot make meaningful decisions, and has to have 24 hour supervision. ... The client also requires assist with all ADL's ... The client is unable to tell staff when she needs to go to the restroom. The client is ambulatory and gait is steady at times. Therefore, client must be closely supervised with ambulation. ... Client is normally compliant with allowing staff to follow the plan of care." The comprehensive assessment evidenced the patient was unable to make meaningful decisions and verbalized and understood and made choices regarding the plan of care.</p> <p>A. The plan of care dated 9/6/12 through 11/4/12 evidenced the patient's medication regime included Haldol 0.5 mg, Tylenol PM, and ambien 5 mg every bedtime. The aides are to cue and remind the patient to self administer the medications at the prescribed times. The plan of care stated, "Safety Measures: Fall precautions, 24 hour supervision."</p>			

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	<p>The plan of care failed to evidence specific interventions developed and implemented for this patient related to the patients risk of falls.</p> <p>B. The record evidenced 3 documents titled "Aide Care Plan" identified as first, second, and third shift dated 4/2/12, 5/7/12, 6/18/12, 7/6/12, 8/3/12, and 9/4/12 that failed to evidence specific interventions to direct the aide to reduce the patient's risk of falls."</p> <p>8. Clinical record 9, start of care 8/15/12, evidenced a comprehensive assessment dated 8/15/12 and a fall risk was assessed to be 50 that stated, "Educated on methods of reducing fall risk ... client v/u [verbalized understanding]; however, needs reinforcement."</p> <p>A. The record evidenced an interdisciplinary note dated 8/15/12 that stated, "Client states that [patient] fell in the BR [bathroom] approximately one month ago and was not using his cane at the time. The client had a CVA [cerebral vascular accident] in 1990 ... right side weak - ... right arm is almost flaccid and [patient] walks with a severe limp."</p> <p>B. The plan of care dated 8/15/12 through 10/13/12 with orders for home health aide services failed to evidence</p>						

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	<p>specific interventions for the patient related to the patient's fall risk.</p> <p>C. The record included a document titled "Aide Care Plan" that failed to evidence the specific interventions implemented to address the patients risk of falls.</p> <p>9. The undated policy titled "Skilled Nursing Services" number C-200 stated, "The registered nurse: ... regularly reevaluates the client needs. ... Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... Supervises and teaches other nursing personnel and home health aides as appropriate."</p> <p>10. On 10/30/12 at 3:45 PM, employee A indicated she did not see how the agency could possibly train the aides on every piece of equipment.</p> <p>11. On 10/31/12 at 9:40 AM, employee B indicated she noted an increased number of patient falls in April 2012 and, therefore, falls in the home were addressed in the agency quality improvement program.</p>						

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	12. On 11/2/12 at 8:54 AM, employees A and B indicated the agency did not have a policy and procedure to guide patient transfers in the home when aided by the home health agency staff.			

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G0177	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse counseled the family to meet the identified needs in 1 of 5 (7) clinical records reviewed of patients with aide observation creating the potential for treatment omission and patient harm for all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record 7, start of care 6/7/07, evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p> <p>A. The record evidenced a care coordination note dated 6/26/12 that indicated the patient's roommate, a family member, died and the patient would be moving in with another relative.</p>	G0177	G-0177 The Agency assesses each patient's home environment for safety related to environmental concerns at time of admission to care and whenever there is a change in the patient's condition necessitating a change in how activities of daily living are completed. When there is a need for home modifications the Registered Nurse will make the recommendations to the patient and caregiver. If there is the feasibility of monetary assistance from Area 9 for home modifications(i.e., wheelchair ramp) the Skilled Nurse will report her assessment to the area 9 Case Worker. The Skilled Nurse will also report her findings to the physician. The Registered Nurse (employee A) has received a disciplinary action and counseled regarding her failure to re-evaluate the patient's environment for safety needs at the time of the change of residence on 11/14/2012. The Registered Nurse has been re-educated on the necessity to evaluate each home for environmental safety to ensure the patient's basic ADL and IADL needs can be safely met in the residence. The Agency will ensure on-going compliance with this requirement by auditing	11/19/2012			

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	<p>B. The record evidenced an "Interdisciplinary Note" dated 7/10/12 that stated, "Updated address et [and] that client is no longer living alone."</p> <p>C. The record failed to evidence a nurse evaluated the patient's new environment and taught and educated the new care givers regarding safety precautions related to the patients risk of falls.</p> <p>2. On 11/2/12 at 8:54 AM, Employee A indicated the aide continued to provide hands on care and assistance as ordered on the plan of care after the patient moved to a new environment and home and prior to the registered nurse assessing the area for fall risks and concerns related to the provision of patient care by the home health aide. She indicated the patient 's new home and environment was not assessed until the scheduled visited on 7/29/12 and indicated she had not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p>		100% of all clinical records at start-of-care and whenever there is a significant change-in-condition to ensure the Registered Nurse has assessed the patient's home related to environmental safety and potential adaptive aides that would facilitate safety. The Administrator and the Director of Nursing are responsible for ensuring on-going compliance with this requirement.		

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N0000	<p>This was a state home health relicensure survey conducted as part of a consent decree.</p> <p>Survey Dates: October 29, 30, and 31 and November 1 and 2, 2012</p> <p>Facility #: 004091</p> <p>Medicaid Vendor #: 200806840</p> <p>Surveyors: Bridget Boston, RN, PHNS, Team Leader</p> <p style="text-align: center;">Susan E. Sparks, RN, PHNS, Team Member</p> <p>Census by Service Type (Unduplicated Last 12 Months)</p> <p>Skilled Patients 34 Home Health Aide Only Patients 20 Personal Service Only Patients 2 Total Patients 85</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">November 9, 2012</p>	N0000					

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N0408	<p>410 IAC 17-10-1(d) Licensure Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following:</p> <p>(1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the Alternate Director of Nursing management change had been reported to the ISDH in 1 of 1 agency with the potential to affect all the patients of the agency. (K)</p> <p>Findings:</p>	N0408	N-0408 The Agency notified the ISDH of the previous DON no longer working for the agency on October 18, 2012. The Agency replaced the previous Director of Nursing/Alternate Administrator and submitted all required documents to the ISDH. ISDH responded on October 22, 2012 with a letter approving the New Director of Nursing/Alternate Administrator. The Alternate	11/20/2012			

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	<p>1. On 10/29/2012 at 12:15 PM, the Administrator, Employee A, indicated they had hired a new Alternate Director of Nursing, employee K, and she was in training. The Administrator indicated the state had been notified.</p> <p>2. On 11/05/2012 at 12:30 PM, a request was sent to the ISDH for verification of the notification of change in the Alternate Director of Nursing. On 11/05/2012 at 12:45 PM, the ISDH informed the surveyor via email the agency had not informed the state of a change in the management at the Alternate Director of Nursing position.</p>		<p>Director of Nursing position remains an open position. (The individual hired for this position had only worked a couple of days in the office and it was determined this individual did not have the experience or credentials for the position of Alternate Director of Nursing.) The Agency continues to advertise in the newspaper and with flyers in multiple locations in the community for the position. The Agency will immediately notify the ISDH with the required documents when the Alternate Director of Nursing position is filled with an appropriate candidate. The Administrator is responsible for ensuring on-going compliance with this requirement.</p>		

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N0454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to:</p> <ul style="list-style-type: none"> <li>(1) respond to an emergency;</li> <li>(2) provide guidance to staff;</li> <li>(3) answer questions; and</li> <li>(4) resolve issues;</li> </ul> <p>within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure the new Alternate Director of Nursing was qualified in 1 of 1 management changes with the potential to effect all 33 patients. (K)</p> <p>Findings:</p> <p>1. On 10/29/2012 at 12:15 PM, the Administrator, Employee A, indicated they had hired a new Alternate Director of Nursing, employee K, and she was in training. The Administrator indicated the state had been notified.</p> <p>On 10/29/2012 at 2:00 PM, the personnel file of the new Alternate Director of Nursing was requested and presented to the surveyors. The resume was scanned and sent to the ISDH on</p>	N0454	<p>N-0454 The Alternate Director of Nursing position remains an open position. (The individual hired for this position had only worked a couple of days in the office and it was determined this individual did not have the experience or credentials for the position of the Alternate Director of Nursing.) The Agency continues to advertise in the newspaper and with flyers in multiple locations in the community. The Agency will immediately notify the ISDH with the required documents when the Alternate Director of Nursing position is filled with an appropriate candidate. The Administrator is responsible for ensuring on-going compliance with this requirement.</p>	11/20/2012	

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	<p>11/5/12 at 12: 30 PM.</p> <p>2. On 11/05/2012 at 12:30 PM, a request was sent to the ISDH for verification of the notification of change in the Alternate Director of Nursing.</p> <p>3. On 11/05/2012 at 12:45 PM, the ISDH informed the surveyor via email the agency had not informed the state of a change in the management at the Alternate Director of Nursing position. The email also identified the nurse hired to be The Alternate Director of Nurse was not qualified to be a Alternate Director of Nursing due to a lack of supervisory experience.</p>			

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N0470	<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, policy review, agency document review, and interview, the agency failed to ensure the staff followed infection control practices for 2 of 5 (5 and 7) home health aide visits observed resulting in the potential to affect all current 33 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 10/30/12 at 1:30 PM, during a home visit observation to patient #5, employee C indicated she does not have access to disposable towel in the patient's home and did not have hand sanitizer with her. She indicated after completing hand washing, she dries her hands on the patient's cloth towel that hangs on the towel rack and was used all day.</li> <li>2. During a home visit to the home of patient # 7, on 10/31/12 at 10:10 AM, employee J was observed to dry her hands on a cloth towel hanging in the shared household bathroom. She indicated she used the towel all day long while working in the home. The towel was draped over</li> </ol>	N0470	N-0470 CJ'S Abundant Care will ensure all staff follows standard infection control practices. The Agency has provided all field employees with paper towels and hand sanitizer by 11/11/2012. All field employees have been in-serviced and competency tested on hand washing, use of paper towels, and hand sanitizer. All staff were in-serviced by 11/11/2012. The Agency will evaluate staff compliance through weekly random employee supervisory visits. The Administrator and Director of Nursing are responsible for ensuring on-going compliance with this requirement.	11/12/2012			

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	<p>a wooden hook in the bathroom and the bottom tip of the towel was approximately one inch above a pile of clothing.</p> <p>3. The undated policy titled "Infection Prevention / Control" number B-403 stated, "CJ's Abundant Care will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC)."</p> <p>4. The Centers for Disease Control "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, " IV. Standard Precautions . . . IV.A. Hand Hygiene. 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 . . . IV.A.3. Perform hand hygiene: . . . IV.A.3.b. After contact with excretions, mucous membranes, . . . IV.A.3.d. If hands will be moving from a contaminated body site to a clean body site during patient care."</p> <p>5. The undated policy titled "Standards of practice" stated, "CJ's Abundant Care will provide services that are in compliance</p>						

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	with acceptable professional standards for the Home Care industry as well as all state and federal laws and identified agency performance improvement standards."			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure the care provided followed a physician ordered plan of care in 6 of 10 clinical records reviewed creating the potential for treatment omission and patient harm and affect all the patients of the agency. (1, 4, 6, 8, 9, and 10)</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care 8/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 8/24/12 through 10/22/12. The plan of care was three pages in total and at the top of the 3 pages stated, "Sep - 05-2012 (WED) 12:49." The record evidenced a facsimile face sheet attached to the plan of care dated 9/5/12 that stated, "Dr [Name] ... Please sign / date and fax back," 13 days after the start of care. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p>	N0522	N-0522 CJ's Abundant Care ensures that all patient care is provided as directed by a physician. The Admission Process will include the following changes: a. At time of acceptance of a patient referral, the Skilled Nurse will obtain a verbal order from the Physician to "assess and evaluate" the patient for appropriateness for home health care services. The verbal order to assess and evaluate the patient will be documented on a Physician Order Form containing the services needed and the specific type of treatment/care to be provided upon SOC. b. Immediately following the comprehensive assessment, the registered nurse contacts the physician with his/her assessment findings. The physician and registered nurse collaborate on the development of the Plan of Care. a. The documentation of this physician contact will be located on a Clinical addendum form attached to the comprehensive assessment. b. This documentation will contain the following: i. Dr. _____ has been notified of the assessment	11/19/2012			

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	<p>On 11/2/12 at 8:54 AM, employee A indicated the plan of care was the verbal order.</p> <p>2. Clinical record 4, start of care 10/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 10/24/12 through 12/22/12 with orders for home health aide services only 3-5 hours per day, 4-5 times a week through out the certification period. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>A. During a home visit on 10/30/12 at 11 AM, the patient indicated home health aide services began on 10/25/12.</p> <p>B. On 11/2/12 at 8:54 AM, employee A indicated the plan of care was the verbal order for admission for home health services.</p> <p>3. Clinical record # 6, start of care 6/5/09, evidenced a recertification comprehensive assessment dated 10/3/12 that identified the patient was at risk of falls. The attending physician ordered</p>		<p>findings on _____ at _____.</p> <p>ii. Communication of the assessment findings. (Clinical Addendum) iii. The services to be provided including disciplines, frequency of services, and type of services to be provided. iv. A verbal order will be obtained and documented on a physician verbal order form containing disciplines, frequency of services, and type of treatment/services to be provided. c. The detailed physician orders resulting from this discussion are documented on the Plan of Care (485) document. The orders include the following: i. The patient's diagnoses ii. A listing of the patient's medications including dosage and frequency of administration iii. The disciplines ordered iv. The services to be provided v. The frequency and duration of the services vi. The specific tasks each discipline is to provide vii. Identification of any high risk parameters for notifying the physician such as the following: 1. Vital Sign Parameters 2. PT/INR Parameters for patients on anticoagulant therapy 3. Blood sugar parameters for diabetic patients viii. The goals of the care to be provided d. The information as documented on the "Clinical Addendum" is repeated in the Plan of Care (485) at the bottom of Locator 21, including the date and time of</p>				

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	<p>physical therapy, occupational therapy, speech therapy, and wound care on 10/5/12. The record failed to evidence the patient received the ordered services. The record failed to evidence a physician order to discontinue the ordered therapy services.</p> <p>On 11/2/12 at 8:54 AM, employee A indicated the record did not evidence therapy services had been provided. She indicated she notified the physician the patient declined the ordered services.</p> <p>4. Clinical record 8, start of care 5/15/11, included a plan of care for the certification period 9/6/12 through 11/4/12. The record evidenced a skilled nurse visit note dated 8/3/12 documented by employee A that stated, "U/A C &amp; S per I &amp; O cath." The record failed to evidence a physician order to collect a urine sample via an catheter.</p> <p>On 11/2/12 at 10:30 AM, employee A was asked if there was a physician order for the use of a catheter to collect urine sample. Employee A indicated she only wrote on the nurses note and the record does not evidence a written physician order.</p> <p>5. Clinical record 9, start of care 8/15/12 evidenced a comprehensive assessment</p>		<p>physician contact and the Admission Summary of the assessment findings. e. The Admission Summary provides validation of the collaboration in the development of the Plan of Care between the Physician, Registered Nurse, and Patient/Caregiver. The Summary also includes a summation of the assessment findings, patient condition, and need for services. f. In addition: Locator 23 of the Plan of Care (485) is the box designated for the Registered Nurse to indicate when he/she obtained physician orders for the "verbal start of care" by documenting the Registered Nurse signature and the date he/she received the verbal orders to initiate services for the Plan of Care. g. The Physician's signature of the document (Plan of Care/485) is a confirmation that the discussion took place and an authorization of the physician orders as written. Registered Nurse Case Managers will be re-educated on this process and their responsibilities to obtain physician orders for the development of the Plan of Care and all additional supplemental physician orders as patient needs change through-out the 60-day episode of care. (Date: 12/12/2012). The Agency will ensure on-going compliance with this requirement. The Agency will audit 100% of all clinical records at start-of-care,</p>		

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	<p>dated 8/15/12 and a plan of care dated 8/15/12 through 10/13/12. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>On 11/2/12 at 10:35 AM, employee A indicated the plan of care was the verbal order and admission to home care.</p> <p>6. Clinical record 10, start of care 9/5/12, evidenced a comprehensive assessment dated 9/5/12 and a plan of care dated 9/5/12 through 11/3/12. The record failed to evidence a physician order to admit the patient for home care services. The record failed to evidence verbal orders had been obtained and evidenced the patient was receiving services from the agency.</p> <p>On 11/2/12 at 10:35 AM, employee A indicated the plan of care was the verbal order and admission to home care.</p> <p>7. The policy titled "Plan of Care" dated 2/14/12 stated, "An individualized Plan of Care signed by the physician shall be required for each client receiving home</p>		<p>resumption-of-care, recertification, transfer, and discharge to ensure the clinician has obtained and documented physician orders for the provision of care. The Administrator is responsible for ensuring compliance with this requirement.</p> <p>Clinical Record #6 and #8: The registered nurse has been counseled regarding the failure to obtain required physician orders on 11/14/2012. The registered nurse has been in-serviced on the necessity to obtain physician orders for all procedures and to document all physician orders and communication with the physician. See Attachments</p>				

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	health and personal care services. The plan of care shall be completed in full to include: ... Any safety Measures to protect against injury, Instructions to client / caregiver."			

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on observation, interview, and clinical record and policy review, the agency failed to ensure all patients had an individualized plan of care that included specific fall prevention interventions in 7 (# 1, 2, 3, 4, 5, 7, and 9 ) of 10 clinical records reviewed creating the potential for treatment omission and patient harm and affect all the patients of the agency.</p> <p>Findings include:</p>	N0524	N-0524 The Agency will address patient safety in the Physician Plan of Care under Locator #15, and Locator #21. These sections address each patient's specific safety needs based on each patient's "patient specific" comprehensive assessment. Locator #21 will also include Home Safety directions specific to each patient. CJ'S Abundant Care utilizes the following screens to identify each patient's safety and fall risks: a. Fall Risk Assessment in the	12/01/2012			

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	<p>1. Clinical record 1, start of care (SOC) 8/24/12, evidenced a plan of care (POC) dated 8/24/12 through 10/22/12 with orders for a home health aide 4 - 6 hours per day 5- 7 days a week throughout the certification period to assist with ambulation and mobility and a skilled nurse visit once a month for "Assess / instruct on home safety management / falls preventions." The POC stated, "Initial Summary ... Client also has pain in her legs / feet ... client's pain is all the time and is worst with ambulation and better with rest, ... Client is SOB [short of breath] with moderate exertion. ... Client uses a rolling walker for ambulation, has steady gait with rolling walker but has poor endurance. .... Client is in need of a home health aide for ADL's [activities of daily living] I.E.: Bathing, dressing, grooming, ... due to her chronic pain, SOB, and muscle weakness. ... Safety Measures: ... Fall Precautions ... Goals: ... Client will demonstrate safe functional ambulation with assistive device." The plan of care failed to evidence specific fall prevention interventions for the staff to implement while providing care to this patient that addressed the identified risks of fall.</p> <p>2. Clinical record 2, SOC 4/23/12, evidenced a plan of care dated 10/21/12 through 12/19/12 that included orders for</p>		<p>Comprehensive Assessment Tool b. Timed Up and Go Test c. Risk of Hospitalization Screens The Agency has held training and competency testing for the home health aides on use of adaptive equipment devices and patient transfer procedures. (11/01/2012) The Agency has conducted additional home health aide training and competency testing on "patient transfer techniques" on 11/19/2012. The Home Health Aide Care Plan will be individualized to meet each patient's personal care and safety needs. Personal Care Guidelines and Fall Prevention Guidelines will be attached to the Home Health Aide Plan of Care to provide specific individualized guidance. This document will be reviewed every 60 days or whenever there is a significant change-in-condition and updated as needed to meet the patient's needs. All Home Health Aide Care Plans will be updated with the guidelines by 12/1/2012. Patient's # 1, 2, 3, 4, 5, 7, &amp; 9 will receive additional safety assessments and education specific to their needs by 11/19/2012. The Agency will ensure on-going compliance with patient safety through clinical record audits at Start-of-Care, Recertification, /Resumption and whenever there is a significant-change-in-condition. In addition patient safety will be reviewed at the home health aide</p>	

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	<p>home health aide 1 - 3 hours, 1 - 3 times a day, 6 - 7 days a week throughout the certification period to assist with ambulation and mobility. The POC stated, "Safety Measures: ... Fall Precautions ... lock w/c [wheelchair] with transfers ... Goals: ... Client will demonstrate safe functional ambulation with walker / wheelchair mobility." The record included three documents titled "Aide Care Plan" dated 10/15/12 for 3 specific shifts, first, second, and third. The plan of care failed to evidence specific fall prevention interventions for the staff to implement while providing care to this patient that addressed the identified risks of fall.</p> <p>3. Clinical record 3, SOC 4/11/12, evidenced a plan of care dated 10/8/12 through 12/6/12 with the diagnosis of Legal Blindness and orders for a home health aide 3-4 hours a day, 4-5 times a week for 9 weeks. The plan of care failed to specify the specific intervention the aide was to follow while rendering care to the patient to prevent falls.</p> <p>4. Clinical record 4, start of care 10/24/12, evidenced a plan of care dated 10/24/12 through 12/22/12 and orders for home health aide services only 3-5 hours per day, 4-5 times a week throughout the certification period, Safety Measures: Fall</p>		<p>supervisory visits, and random administrative supervisory visits. The Administrator and Director of Nursing are responsible for ensuring compliance with this requirement.</p>				

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	<p>precautions, and diagnosis Seizures. The plan of care failed to evidence the specific interventions for the aide to follow to prevent falls.</p> <p>On 10/30/12 at 11 AM, the patient indicated seizure activity occurred every day.</p> <p>5. Clinical record 5, start of care 12/7/10, included a plan of care for the certification period 9/27/12 through 11/25/12 with orders for aide only services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific interventions for the aide to follow to prevent falls.</p> <p>6. Clinical record 7, start of care 6/8/07, evidenced a sixty day summary dated 9/7/12 that stated, "The client can stand for short period to pivot with transfers, but becomes SOB [short of breath] with minimal exertion. The clients right side is</p>			

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	<p>almost flaccid, has minimal use of right arm / right leg."</p> <p>The record evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation, and mobility. The plan of care failed to evidence the specific interventions for the staff to follow to prevent falls, related to the patient's identified risk factors.</p> <p>7. Clinical record 9, start of care 8/15/12, evidenced a comprehensive assessment dated 8/15/12 and a fall risk was assessed to be 50 that stated, "Educated on methods of reducing fall risk ... client v/u [verbalized understanding]; however, needs reinforcement."</p> <p>The record evidenced a plan of care dated 8/15/12 through 10/13/12 with Safety Measures identified as Fall Precautions. The Plan of care failed to evidence the specific interventions for the staff to follow to prevent falls.</p> <p>8. The policy titled "Plan of Care" dated 2/14/12 stated, "An individualized Plan of Care signed by the physician shall be</p>			

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	required for each client receiving home health and personal care services. The plan of care shall be completed in full to include: ... Any safety Measures to protect against injury, Instructions to client / caregiver."			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 1 of 10 records reviewed (#8) with the potential to affect all the patients receiving skilled nursing services from the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 8, start of care 5/15/11, included a plan of care for the certification period 9/6/12 through 11/4/12. The record evidenced a skilled nurse visit note dated 8/3/12 documented by employee A, registered nurse, that stated, "U/A C &amp; S per I &amp; O cath." The record failed to evidence a physician order to collect a urine sample via an catheter.</li> <li>2. On 11/2/12 at 10:30 AM, employee A was asked if there was a physician order for the use of a catheter to collect urine sample. Employee A indicated she only wrote on the nurses note and the record does not evidence a written physician order.</li> </ol>	N0537	N-0537 The Agency will ensure all patient care is provided per physician orders. The Skilled Nurse (employee A) has received a disciplinary action and counseled on the necessity for physician orders for all treatments and procedures on 11/14/2012 The Administrator will ensure on-going compliance through clinical record audits(all clinical records are audited at the time of admission, recertification, resumption of care, transfer, and discharge.) The Administrator is responsible for ensuring compliance with this requirement.	11/19/2012			

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N0541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on a home visit observation, clinical record and policy review, and interview, the agency failed to ensure the registered nurse re-evaluated the patients' needs after an identified unsafe incident or change in environment in 2 (5 and 7) of 5 aide home visit observations with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record 5, start of care 12/7/10 included a plan of care for the certification period 9/27/12 through 11/25/12 with orders for aide services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific individualized</p>	N0541	<p>N-0541 The Agency will ensure all patients are regularly re-evaluated following any incident regarding patient safety, with any health concern, or environmental change, The Skilled Nurse ( Employee A) has received a disciplinary action and counseled on 11/14/2012 regarding her failure to re-evaluate the patient following the incident and provided education regarding her responsibilities to re-evaluate all patients following any safety and/or health incidents in the home and when the patient changes his/her place of residence. The Skilled Nurse has been re-educated on the assessment, education, and reporting responsibilities of the RN Case Manager on 11/14/2012 Home Health Aide Care Plans will include the document "Guidelines for Safety in Personal Care and Fall Prevention". Each patient will have their own individualized guideline that will be given to the home health aide. The home health aides will receive instruction on these guidelines and there will be a</p>	12/01/2012			

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	<p>interventions implemented for this patient to prevent falls.</p> <p>A. The record evidenced an Aide Care Plan dated 6/11/12, 7/23/12, 8/23/12, and 9/24/12 that stated, "Patient problem: Alzheimer ... hx [history] of falls ... Precautionary and other pertinent information ... Lives alone ...up as tolerated ... fall precautions ... forgetful." The Aide Care Plan failed to specify the specific fall precautions and strategies for the aide to follow while rendering care for this patient.</p> <p>B. On 10/30/12 at 1:30 PM, employee C was observed to cue the patient to ambulate approximately 20 feet from the living room, through a bedroom, and into a full bathroom, while propelling a four wheeled walker (4 WW). Employee C did not remind, cue, or instruct the patient or engage the brakes on the 4WW and the employee did not engage the brakes of the walker herself prior to requesting the patient to rise from a seated position. After the patient and aide reached their destination in the bathroom, the aide did not engage the brakes on the walker and did not cue the patient to engage the brakes. After the patient showered, the patient was sitting on the seat of the 4 WW in the bathroom. The aide instructed the patient that it was</p>		<p>copy of the guideline in every home folder of patients receiving home health aide services. The Home Health Aide Care Plan and Guideline will be updated with any patient change-in-condition and reviewed at least every 60 days. All Home Health Aide Care Plans will be updated with the guidelines by 12/1/2012 Patients #5 and #7 have been re-evaluated and their clinical records evidence documentation of the assessment, the physician has been notified if any provision of care changes were needed, and the home health aide care plan reviewed and updated if needed. The Administrator will ensure on-going compliance through home observations of the RN providing patient care, tracking of patient falls with the PI program, and clinical record audits (all clinical records are audited at time of admission, recertification, resumption-of-care, transfer, and discharge). 10% of all clinical records are reviewed quarterly. The Administrator is responsible for ensuring compliance with this requirement.</p>				

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	<p>time to brush his / her teeth. The patient was not wearing any footwear. The aide placed a folded towel on the floor at an angle to the sink and counter; the right 2 corners of the towel were nearest the left side of the sink. While the patient was seated on the attached seat of the 4 WW, the aide pulled the patient towards the sink and placed the patient at the same angle to the sink as the towel on the floor; the right side of the 4WW was against the sink and counter. The aide assisted the patient to rise from the seated position and instructed the patient to stand on the towel folded on the floor. This placed the patient standing left of center of the sink, on top of a folded towel, without footwear, attempting to brush his / her dentures and teeth, and spit into the sink / bowl which was to the patient's right. Without notice, the patient lost balance and fell backwards, buttocks falling below the seat of the 4WW. The walker was not locked and traveled away from the aide and patient until the left wheel hit a cabinet along the bathroom wall. The aide grabbed the patient's right arm and lifted the patient up and onto the seat of the 4 WW. After patient lost balance, the handles of the 4 WW rotated freely, only stopped by the brake cables attached and the brakes were not working on the 4WW. Neither the aide nor the patient had attempted to engage the brakes of the</p>			

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	<p>4 WW throughout the observation.</p> <p>Employee C indicated the handles of the walker were missing screws for about a week and she was not aware the brakes were not working.</p> <p>C. On 11/2/12 at 8:54 AM, employee A indicated a registered nurse had not visited and evaluated the patient since the home visit of 10/30/12 at 1:30 PM in which the patient lost balance and the patient was in receipt of a new four wheeled walker.</p> <p>2. Clinical record 7, start of care 6/7/07, evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p> <p>A. The record evidenced a care coordination note dated 6/26/12 that indicated the patient's roommate, a family member, died and the patient would be moving in with another relative.</p> <p>B. The record evidenced an</p>			

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	<p>"Interdisciplinary Note" dated 7/10/12 that stated, "Updated address et [and] that client is no longer living alone."</p> <p>C. The record failed to evidence a nurse evaluated the patient's new environment and taught and educated the new care givers regarding safety precautions related to the patients risk of falls.</p> <p>D. On 10/31/12 at 10:10 AM, employee J was observed transferring the patient from a wheelchair and onto a shower bench which sat inside a regular size bathtub located to the patient's right side. The shower / tub did not have any grab bars and the aide did not use a gait belt during the transfer or any other transfer - safety device. The patient's right arm was flaccid and the aide held onto the right arm during both transfers in and out of the tub. The patient required hands-on maximum assistance of the aide to be repositioned on the shower bench; lifting the patient's right leg completely. The patient was stood by the aide onto a clay / ceramic tile floor without placing footwear on the patient. After the patient was transferred into the tub, the patient's right leg began to tremor and the patient complained of pain related to the tremor. There was only one grab bar in the bathroom and it was located near the</p>						

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	<p>commode and would be on the patient's left and functional side.</p> <p>D. On 11/2/12 at 8:54 AM, Employee A indicated the aide continued to provide hands on care and assistance as ordered on the plan of care after the patient moved to a new environment and home and prior to the registered nurse assessing the area for fall risks and concerns related to the provision of patient care by the home health aide. She indicated the patient 's new home and environment was not assessed until the scheduled visited on 7/29/12 and indicated she had not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p> <p>3. The undated policy titled "Skilled Nursing Services" number C-200 stated, "The registered nurse: ... regularly reevaluates the client needs. ... Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... Supervises and teaches other nursing personnel and home health aides as appropriate."</p> <p>4. On 10/30/12 at 3:45 PM, employee A indicated she did not see how the agency</p>				

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	<p>could possibly train the aides on every piece of equipment.</p> <p>5. On 10/31/12 at 9:40 AM, employee B indicated she noted an an increased number of patient falls in April 2012 and, therefore, falls in the home were addressed in the agency quality improvement program.</p> <p>6. On 11/2/12 at 8:54 AM, employees A and B indicated the agency did not have a policy and procedure to guide and patient transfers in the home when aided by the home health agency staff.</p>				

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N0543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the registered nurse initiated appropriate preventative and rehabilitative procedures for the patient risks identified on the comprehensive assessment in 8 of 10 (1, 2, 3, 4, 5, 7, 8, and 9) clinical records reviewed of patients with orders for home health aide services, creating the potential for treatment omission and patient harm for all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record 1, start of care (SOC) 8/24/12, included a comprehensive assessment dated 8/24/12 completed by employee K. The comprehensive assessment included a fall risk assessment. The assessor determined the patient had a fall risk of 40. The document stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2.</p>	N0543	N-0543 Patients 1, 2, 3, 4, 5, 7, 8, and 9 will have a reassessment of their patient risks and will be re-educated in strategies specific to their areas of risk by 11/19/2012. The Home Health Aide Care Plans will be updated to reflect patient specific needs and areas of weakness. Physician orders will be written as needed. All Home Health Aide Care Plans will be updated by 12/1/2012 Home Health Aide Care Plans will include the document "Guidelines for Safety in Personal Care and Fall Prevention". Each patient will have their own individualized guideline that will be given to the home health aide. The home health aides will receive instruction on these guidelines and there will be a copy of the guideline in every home folder of patients receiving home health aide services. The Home Health Aide Care Plan and Guideline will be updated with any patient change-in-condition and reviewed at least every 60 days. All Home Health Aide Care Plans will be updated with the guidelines by 12/1/2012. The Administrator	12/01/2012			

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	<p>Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient. Hand written below the score of 40, it stated, " Pt. [patient] refuses any referrals for therapy."</p> <p>The record evidenced a plan of care (POC) dated 8/24/12 through 10/22/12 with orders for a home health aide 4 - 6 hours per day 5- 7 days throughout the certification period to assist with ambulation and mobility and a skilled nurse visit once a month for "Assess / instruct on home safety management / falls preventions." The POC stated, "Initial Summary ... Client also has pain in her legs / feet ... client's pain is all the time and is worst with ambulation and better with rest, ... Client is SOB [short of breath] with moderate exertion. ... Client uses a rolling walker for ambulation, has steady gait with rolling walker but has poor endurance. .... Client is in need of a home health aide for ADL's [activities of daily living] I.E.: Bathing, dressing, grooming, ... due to her chronic pain, SOB, and muscle weakness. ... Safety Measures: ... Fall Precautions ... Goals: ... Client will demonstrate safe functional ambulation with assistive device." The record included a document titled "Aide Care Plan" dated 8/24/12. The POC and Aide Care Plan failed to</p>		<p>will ensure on-going compliance through home observations of the RN providing patient care, tracking of falls with the PI program, and clinical record audits( all clinical records are audited at time of admission, recertification, resumption of care, transfer, discharge). 10% of all clinical records are reviewed quarterly. In addition all Home Health Aides have been retrained and competency tested on adaptive devices. (11/01/12) All Home Health Aides are being retrained and competency tested on transfer techniques. This in-service and competency is scheduled for 11/19/12. The Agency will evaluate field staff compliance through weekly random employee supervisory visits. Employees observed not following standards of practice with patient transfers will have to go through further retraining and competency testing before being allowed to continue to provide care in the patient home environment. The Administrator and the Director of Nursing are responsible for ensuring on-going compliance with this requirement.</p>		

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	<p>evidence specific fall prevention interventions and instructions for the aide to follow while providing care to this patient that addressed the identified unsteady gait.</p> <p>2. Clinical record 2, SOC 4/23/12, included a recertification comprehensive assessment dated 10/15/12 completed by employee A. The assessment stated, "Primary diagnosis - Muscle Weakness, other diagnosis, chronic pain ... abnormality of gait ... Pain ... ongoing, location - back, duration - constant ... dyspnea with minimal exertion ... Unsteady gait has walker or w/c [wheelchair]. Fall risk assessment ... 45. ... Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient."</p> <p>A. The plan of care dated 10/21/12 through 12/19/12 included orders for home health aide 1 - 3 hours, 1 - 3 times a day, 6 - 7 days a week throughout the certification period to assist with ambulation and mobility. The POC stated, "Safety Measures: ... Fall Precautions ... lock w/c [wheelchair]"</p>						

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	<p>with transfers ... Goals: ... Client will demonstrate safe functional ambulation with walker / wheelchair mobility." The record included three documents titled "Aide Care Plan" dated 10/15/12, one for each shift -first, second, and third. The The POC and Aide Care Plans failed to include the specific fall prevention interventions for the aide to follow while providing direct care to this patient.</p> <p>B. On 10/30/12 at 9:35 AM, employee E was observed to assist patient # 2 to transfer between surfaces twice without the aide of a gait belt or other adaptive equipment to support and stabilize the patient during the transfer. The aide did not position herself in relationship to the patient to promote and allow physical support and stabilize the patient in the event the patient lost balance during the transfer.</p> <p>C. During the first transfer observed, the patient was seated in a lounge chair and the aide placed a wheelchair at the foot and at 90 degrees to the left of the lounge chair. When the patient began to rise from the lounge chair, the aide stood between the lounge chair and the wheelchair, on the left of the lounge chair and the right of the wheelchair, between the two items. She placed her hands under the patient's arms</p>						

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	<p>from behind while standing to the left of the lounge chair. The patient was not able to clear the right arm rest of the wheelchair and the aide offered no physical assistance. The patient brushed buttocks over the side arm of the wheelchair until over the seat. The patient did not lift self over the side arm of the wheelchair.</p> <p>D. During the second transfer, the aide placed the patient, while seated in a wheelchair, directly in front of a bedside commode. The patient was then transferred between the two surfaces, turning 180 degrees, with a pivot transfer and slouched position. During the transfer, the aide did not use a gait belt or other adaptive equipment to stabilize the patient. There were no grab bars available and the aide placed her hands under the patients arms, from behind the patient, while the patient transferred from the wheelchair to the bedside commode.</p> <p>E. The patient indicated another aide, employee D, assisted with transfers differently. The patient indicated employee D provided care in the evenings and prepared the patient for the night and indicated employee D physically picked up the patient. The patient placed her / his hands just below the ribs and above the hips to indicate where employee D</p>			

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	<p>placed his hands and said, "It hurts" when he / she was transferred in this manor. The patient indicated employee D feared the patient would fall during transfers and did not want the patient to participate.</p> <p>F. On 11/2/12 at 8:54 AM, employee A indicated a gait belt was added to the aide assignment sheet on 10/30/12 after the problem was identified during the home visit. She further indicated the agency did not issue a gait belt to the aide to use or to the patient to be kept in the house for all aides to use during patient transfers and stated, "She [the aide] would just have to grab her if she started to fall." Employee B confirmed the observation of employee E on 10/30/12 and indicated the employee did not properly position herself when transferring the patient from the lounge chair and a gait belt was not used.</p> <p>3. Clinical record 3, SOC 4/11/12, included a recertification comprehensive assessment dated 10/3/12 completed by employee A. The assessment stated, "Legally Blind, other diagnosis - chronic pain, urinary incontinence, ... , malaise / fatigue, CKD [chronic kidney disease. ... Pain ... makes it difficult to complete ADL's [activities of daily living]. ... Fall risk assessment ... 45. ... Implement fall precautions for a total score of 15 or</p>				

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	<p>greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient. ... Rehabilitation Potential Goals ... Aide: Client to remain safe within [his / her] home AEB [as evidenced by] 0 [no] falls +/- [throughout] cert [certification period]."</p> <p>The record evidenced a plan of care dated 10/8/12 through 12/6/12 with orders for a home health aide 3-4 hours a day, 4-5 times a week for 9 weeks. The record also evidenced Aide Care Plans dated 4/11/12, 6/9/12, 8/7/12, and 10/3/12 that evidenced fall precautions. The plan of care and aide care plans failed to specify the specific intervention the aide was to follow while rendering care to the patient to prevent falls.</p> <p>4. Clinical record 4, start of care 10/24/12, included a comprehensive assessment dated 8/24/12 and a plan of care dated 10/24/12 through 12/22/12 with orders for home health aide services only 3-5 hours per day, 4-5 times a week throughout the certification period. The record included an Aide Care Plan that stated, "Patient Problem: Seizures, chronic pain, ... Precautionary and other</p>						

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	<p>pertinent information ... Lives alone ...up as tolerated ... fall precautions ... forgetful / Confused." The aide care plan failed to evidence the specific interventions for the aide to follow specific for this patient.</p> <p>On 10/30/12 at 11 AM, the patient indicated seizures activity occurred every day.</p> <p>5. Clinical record 5, start of care 12/7/10, included a plan of care for the certification period 9/27/12 through 11/25/12 with orders for aide services 3 - 6 hours per day, 6 - 7 days throughout the certification period that stated, "To perform / assist with: personal care, bathing, dressing, grooming, ... assist with ambulation / mobility. ... Safety Measures: ... ambulation with rolling walker ... fall precautions. ... Goals ... Client will continue to demonstrate safe functional ambulation with rolling walker AEB [as evidenced by] no falls during cert period." The plan of care failed to evidence the specific individualized interventions implemented for this patient to prevent falls.</p> <p>A. The record evidenced Aide Care Plans dated 6/11/12, 7/23/12, 8/23/12, and 9/24/12 that stated, "Patient problem: Alzheimer ... hx [history] of</p>						

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	<p>falls ... Precautionary and other pertinent information ... Lives alone ...up as tolerated ... fall precautions ... forgetful." The Aide Care Plan failed to specify the specific fall precautions and strategies for the aide to follow while rendering care for this patient."</p> <p>B. On 10/30/12 at 1:30 PM, employee C was observed to cue the patient to ambulate approximately 20 feet from the living room, through a bedroom, and into a full bathroom while propelling a four wheeled walker (4 WW). Employee C did not remind, cue, or instruct the patient or engage the brakes on the 4WW and the employee did not engage the brakes of the walker herself prior to requesting the patient to rise from a seated position. After the patient and aide reached their destination in the bathroom, the aide did not engage the brakes on the walker and did not cue the patient. After the patient showered, the patient was sitting on the seat of the 4 WW in the bathroom. The aide instructed the patient it was time to brush his / her teeth. The patient was not wearing any footwear. The aide placed a folded towel on the floor at an angle to the sink and counter; the right 2 corners of the towel were nearest the left side of the sink. While the patient was seated on the attached seat of the 4 WW, the aide</p>				

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	<p>pulled the patient towards the sink and placed the patient at the same angle to the sink as the towel on the floor; the right side of the 4WW was against the sink and counter. The aide assisted the patient to rise from the seated position and instructed the patient to stand on the towel folded on the floor. This placed the patient standing, left of center of the sink, on top of a folded towel, without footwear, attempting to brush his / her dentures and teeth and spit into the sink / bowl which was to the patient's right. Without notice, the patient lost balance and fell backwards, buttocks falling below the seat of the 4WW. The walker was not locked and traveled away from the aide and patient until the left wheel hit a cabinet along the bathroom wall. The aide grabbed the patient's right arm and lifted the patient up and onto the seat of the 4 WW. After the patient lost balance, the handles of the 4 WW rotated freely, only stopped by the brake cables attached and the brakes were not working on the 4WW. Neither the aide nor the patient had attempted to engage the brakes of the 4 WW throughout the observation. Employee C indicated the handles of the walker were missing screws for about a week and she was not aware the brakes were not working.</p> <p>C. At 2 PM, employee C indicated</p>			

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	<p>she was not aware she needed to inform the agency and nurses of defective equipment left in the home.</p> <p>D. During the home visit, employee B, the administrator, and C, the aide, were unable to find a current aide assignment or aide care plan in the home. Employee B indicated the most recent assignment sheet found in the home was dated 5/26/11. Employee C indicated she received an assignment sheet a few months earlier to take home. She indicated she did not have a current assignment sheet in the home for the aide care delivered on 10/30/12.</p> <p>6. Clinical record 7, start of care 6/8/07, evidenced a recertification comprehensive assessment dated 9/7/12 that stated, "Primary Diagnosis hemiplegia ... other diagnoses ... chronic pain, right hand contracture [sp]. ... Fall risk assessment ... 40. ... Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient." A sixty day summary dated 9/7/12 stated, "The client can stand for short period to pivot with transfers, but becomes SOB [short of breath] with</p>						

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	<p>minimal exertion. The clients right side is almost flaccid, has minimal use of right arm / right leg."</p> <p>A. The record evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 and orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p> <p>B. The record evidenced documents titled "Aide Care Plan" dated 6/25/12, 7/10/12, 8/7/12, and 9/7/12 that failed to evidence specific interventions implemented and directions for the aide related to this patient's abilities and risk of falls while providing patient assistance in the home.</p> <p>C. On 10/31/12 at 10:10 AM, employee J was observed transferring the patient from a wheelchair and onto a shower bench which sat inside a regular size bathtub located to the patient's right side. The shower / tub did not have any grab bars and the aide did not use a gait belt during the transfer or any other</p>						

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	<p>transfer - safety device. The patient's right arm was flaccid and the aide held onto the right arm during both transfers in and out of the tub. The patient required hands-on maximum assistance of the aide to be repositioned on the shower bench; lifting the patient's right leg completely. The patient was stood by the aide onto a clay / ceramic tile floor without placing footwear on the patient. After the patient was transferred into the tub, the patient's right leg began to tremor and the patient complained of pain related to the tremor. There was only one grab bar in the bathroom and it was located near the commode and would be on the patient's left and functional side.</p> <p>D. On 11/2/12 at 8:54 AM, employee A indicated she has not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p> <p>7. Clinical record 8, start of care 5/15/11, evidenced a recertification comprehensive assessment dated 9/4/12 documented by employee A that included a fall risk score of 30 that stated, "Implement fall precautions for a total score of 15 or greater. As guided by organizational guidelines: 1. Educate on fall prevention strategies specific to areas of risk. 2. Refer to physical therapy and / or</p>			

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	<p>occupational therapy. 3. Monitor areas of risk to reduce falls. 4. Reassess patient. ... Client / CG [caregiver] instructed on methods of reducing fall risk: keep pathways clear, wear shoes that fit well, use night light, secure loose rugs, client / CG V/U [verbalized understanding]. Assessment for recertification completed. Client / CG continue wishes to remain a DNR. Order in place. Reviewed when to call agency vs [verse] MD vs 911. CG V/U. ... Client is not oriented, cannot make meaningful decisions, and has to have 24 hour supervision. ... The client also requires assist with all ADL's ... The client is unable to tell staff when she needs to go to the restroom. The client is ambulatory and gait is steady at times. Therefore, client must be closely supervised with ambulation. ... Client is normally compliant with allowing staff to follow the plan of care." The comprehensive assessment evidenced the patient was unable to make meaningful decisions and verbalized and understood and made choices regarding the plan of care.</p> <p>A. The plan of care dated 9/6/12 through 11/4/12 evidenced the patient's medication regime included Haldol 0.5 mg, Tylenol PM, and ambien 5 mg every bedtime. The aides are to cue and remind the patient to self administer the</p>						

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	<p>medications at the prescribed times. The plan of care stated, "Safety Measures: Fall precautions, 24 hour supervision." The plan of care failed to evidence specific interventions developed and implemented for this patient related to the patients risk of falls.</p> <p>B. The record evidenced 3 documents titled "Aide Care Plan" identified as first, second, and third shift dated 4/2/12, 5/7/12, 6/18/12, 7/6/12, 8/3/12, and 9/4/12 that failed to evidence specific interventions to direct the aide to reduce the patient's risk of falls."</p> <p>8. Clinical record 9, start of care 8/15/12, evidenced a comprehensive assessment dated 8/15/12 and a fall risk was assessed to be 50 that stated, "Educated on methods of reducing fall risk ... client v/u [verbalized understanding]; however, needs reinforcement."</p> <p>A. The record evidenced an interdisciplinary note dated 8/15/12 that stated, "Client states that [patient] fell in the BR [bathroom] approximately one month ago and was not using his cane at the time. The client had a CVA [cerebral vascular accident] in 1990 ... right side weak - ... right arm is almost flaccid and [patient] walks with a severe limp."</p>			
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	<p>B. The plan of care dated 8/15/12 through 10/13/12 with orders for home health aide services failed to evidence specific interventions for the patient related to the patient's fall risk.</p> <p>C. The record included a document titled "Aide Care Plan" that failed to evidence the specific interventions implemented to address the patients risk of falls.</p> <p>9. The undated policy titled "Skilled Nursing Services" number C-200 stated, "The registered nurse: ... regularly reevaluates the client needs. ... Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. ... Supervises and teaches other nursing personnel and home health aides as appropriate."</p> <p>10. On 10/30/12 at 3:45 PM, employee A indicated she did not see how the agency could possibly train the aides on every piece of equipment.</p> <p>11. On 10/31/12 at 9:40 AM, employee B indicated she noted an increased number of patient falls in April 2012 and, therefore, falls in the home were</p>				

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	<p>addressed in the agency quality improvement program.</p> <p>12. On 11/2/12 at 8:54 AM, employees A and B indicated the agency did not have a policy and procedure to guide patient transfers in the home when aided by the home health agency staff.</p>				

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N0546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse counseled the family to meet the identified needs in 1 of 5 (7) clinical records reviewed of patients with aide observation creating the potential for treatment omission and patient harm for all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record 7, start of care 6/7/07, evidenced plans of care dated 5/12/12 through 7/10/12, 7/11/12 through 9/8/12, and 9/9/12 through 11/7/12 with orders for home health aide services 2 - 4 hours a day, 1 - 2 times a day, 5 - 6 times a week throughout the certification period to assist with bathing dressing, grooming, ambulation and mobility. The plans of care failed to evidence specific interventions for this patient related to the patient's risk of falls.</p>	N0546	N-0546 The Agency assesses each patient's home environment for safety related to enviornmental concerns at time of admission to care and whenever there is a change in the patient's condition necessitating a change in how activities of daily living are completed. When there is a need for home modifications the Registered Nurse will make the recommendations to the patient and caregiver. If there is the feasibility of monetary assistance from Area 9 for home modifications ( i.e. wheelchair ramp) the Skilled Nurse will report her assessment to the area 9 Case Worker. The Skilled Nurse will also report her findings to the physician. The Registered Nurse (employee A) has received a disciplinary action and counseled regarding her failure to re-evaluate the patient's environment for safety needs at the time of the change of residence on 11/14/2012 The	11/19/2012			

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	<p>A. The record evidenced a care coordination note dated 6/26/12 that indicated the patient's roommate, a family member, died and the patient would be moving in with another relative.</p> <p>B. The record evidenced an "Interdisciplinary Note" dated 7/10/12 that stated, "Updated address et [and] that client is no longer living alone."</p> <p>C. The record failed to evidence a nurse evaluated the patient's new environment and taught and educated the new care givers regarding safety precautions related to the patients risk of falls.</p> <p>2. On 11/2/12 at 8:54 AM, Employee A indicated the aide continued to provide hands on care and assistance as ordered on the plan of care after the patient moved to a new environment and home and prior to the registered nurse assessing the area for fall risks and concerns related to the provision of patient care by the home health aide. She indicated the patient 's new home and environment was not assessed until the scheduled visited on 7/29/12 and indicated she had not watched the aide assist the patient transfer from the wheelchair to the shower bench or reverse in the present home setting.</p>		Registered Nurse has been re-educated on the necessity to evaluate each home for environmental safety to ensure the patient's basic ADL and IADL needs can be safely met in the residence. The Agency will ensure on-going compliance with this requirement by auditing 100% of all clinical records at start-of-care and whenever there is a significant change-in-condition to ensure the Registered Nurse has assessed the patient's home related to environment safety and potential adaptive aides that would facilitate safety. The Administrator and the Director of Nursing are responsible for ensuring on-going compliance with this requirement.		

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N0604	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on observation, personnel record and policy review, and interview, the agency failed to ensure the home health aide followed the agency policies for reporting incidents in 1 of 1 falls observed on survey with the potential to affect all patients receiving aide services. (HV 4 )</p> <p>Findings:</p> <p>1. On October 30, 2012, at 2:00 PM, patient # 5 had finished the shower. The patient was standing in front of the unlocked wheeled walker cleaning the dentures. The patient's legs became weak and the patient attempted to sit on the walker. The walker rolled backwards away from the patient, and the patient's backside fell below the height of the wheeled walkers bench seat. The home health aide, employee C, grabbed the patient by the arms and pulled the patient up to the seat of the wheeled walker. The home health aide, employee C, then indicated the screws were missing from the handles of the walker which affected the working of the brakes, so the brakes were not set. The aide was unaware the</p>	N0604	N-0604 The Agency placed Employee "C" on probation on 10/30/2012 related to her failure to report the nonfunctioning adaptive device in the home setting. All Home Health Aides were in-serviced and competency tested on the correct use of adaptive devices including, cane, quad cane, wheelchair, rolling walker, tub transfer bench, and transfer board, and use of gait belts on 11/1/2012. This in-service including the home health aide is to report any malfunctioning equipment to the RN. All Home Health Aides will be re-inserviced on Incident Reporting, including the home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist including equipment/medical device failure or malfunction. This in-service will take place on 11/19/2012. The Agency will evaluate staff compliance through unannounced random employee supervisory visits. Employees observed not following Incident Reporting Policy and Regulation Rule of The home health aide must report any changes observed in the patient's conditions and needs to the	11/20/2012			

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	brakes were not working.  2. On October 31, 2012, at 9:30 AM, the Administrator, Employee B, presented documentation that evidenced Employee C had been in-serviced on reporting equipment that was broken.  3. On October 31, 2012, at 3:45 PM, the Director of Nursing, Employee A, indicated Employee C had not notified the office about the equipment being broken.  4. On October 31, 2012, at 3:45 PM, the Director of Nursing, Employee A, indicated Employee C had not been in-serviced on proper use of the wheeled walker and we (the Indiana State Department of Health) couldn't possibly expect the agency to in-service the aides on every piece of equipment.  5. A undated policy titled "Incident Reporting", S-340, states, "Special Instructions 1. Staff members will immediately report the incident to their supervisor. An Incident Report form shall be completed in its entirety. ... 8. Incidents to be reported include, but are not limited, to: ... f. Equipment/medical device failure or malfunction"		supervisory nurse or therapist will have immediate disciplinary action up to termination of the employee.				